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MORAL PROBLEMS
IN
HOSPITAL PRACTICE

A PRACTICAL HANDBOOK

BY
THE REV. PATRICK A. FINNEY, C. M
UNIVERSITY OF DALLAS

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INTRODUCTION

The purpose that has led to the preparation of this manual is revealed in its arrangement.

Sisters in charge of hospitals are at times placed in very sudden and very grave doubts about the moral legitimacy of certain surgical operations. The cases giving rise to these doubts are very often emergency cases, and they not unfrequently involve questions of life and death, and hence call for an immediate decision, which a Sister finds it impossible to give under existing circumstances.

Many Catholic hospitals in the West are located in towns in which there is but one priest. It may occur that the local priest happens to be engaged in parochial work away from the rectory, just at the time a Sister desires to appeal to him for a decision; or, if the priest is reached without delay, the case presented to him may be of such a complex nature that it is practically impossible for him to give a prompt and definite decision, owing to the fact that he may not have at hand such works as will enable him to arrive at a satisfactory understanding of the essential points involved in the case. As a result of these conditions there is a delay in obtaining a decision, and this delay may sometimes be serious as far as the patient and doctor are concerned, and to the Sister, it is always

embarrassing. To obviate some of these difficulties, the present manual has been prepared.

The matter has been arranged in such a way that it is hoped a Sister will have no difficulty in reaching a decision within a few minutes after a case is presented to her. The manual consists of two parts, of which the first embodies an effort to cover a wide field of operations and kindred medical cases, in the simple form of question and answer, and the second repeats these questions, and states at some length the principles upon which the answers are based.

Over each question in the first part are placed, in prominent type, a few words indicating the subject-matter of which the question treats. By this arrangement, a Sister, without even referring to the index, may within five minutes run through the whole series of questions covered by the manual.

What a doctor demands, and what a Sister desires to give him, is a decision without delay. This a Sister is enabled to give, by using the first part of the manual. If the decision is favorable, the doctor seldom concerns himself with the principles involved in the decision; but if the decision is unfavorable, he may wish to know the principles upon which the decision is based. To satisfy the wish of any doctor, who may desire to know the reasons on which any decision is based, the second part of the manual has been prepared. This part furnishes a Sister with a ready means of showing a doctor that the decision given in

any particular instance is based upon principles of sound morality. Under each answer in the first part, a reference is given to that place in the second part in which a discussion of principles may be found.

Since the teaching which is prevalent in many medical schools, and which is usually set forth in standard works on Obstetrics, runs counter to the principles upon which many of the decisions are based, it is not to be expected that either the decisions, or the principles upon which they rest, will be acceptable to certain doctors. A Sister, therefore, should not worry if a doctor fails to give his assent to the principles stated and explained in this manual. It is one thing to reject these principles, and it is quite another to refute them by an appeal to sound philosophy and sound morality.

While the manual is intended primarily as a guide for Sisters engaged in hospital work, it is hoped that it may prove helpful also to Catholic doctors, Catholic nurses, and theological students. The last named should find it of some assistance in arriving at a practical understanding of the cases involved in the questions.

As its title indicates, it is a practical manual and not a general treatise on the abstract moral principles that govern medical practice. For this reason, discussions of various opinions upon certain points involved have been studiously avoided throughout the manual, because it was judged that such discussions would serve only to create new doubts, instead of removing those

which it was the primary purpose of the manual to settle.

For the convenience of those who may use the manual, there has been added a complete vocabulary of all medical terms employed in the body of the work. This vocabulary has been taken almost entirely as it stands from the ninth edition of "The American Illustrated Medical Dictionary" by W. A. Newman Dorland, A.M., M.D., F.A.C.S.

If the manual proves at all helpful, it will be largely due to the fact that the following works have been either constantly consulted or liberally drawn upon during the course of its preparation:

"The Ethics of Medical Homicide and Mutilation," by Austin O'Malley, M.D., Ph.D., LL.D. (The Devin-Adair Company, New York.)

"Moral Principles and Medical Practice" by Rev. Charles Coppens, S. J. (Benziger Bros., New York.) New Edition, revised by Rev. Henry S. Spalding, S. J., 1921.

"The Crux of Pastoral Medicine" (Fifth Enlarged Edition), by Rev. Andrew Klarmann, A.M. (Fr. Pustet & Co., New York.)

"The Right to Life of the Unborn Child," by Rev. R. Van Oppenraay, S.J. and Prof. Th. M. Vlaming, M.D. (Joseph F. Wagner, New York.)

"Essays in Pastoral Medicine" by Austin O'Malley, M. D., Ph. D., LL. D. and James J. Walsh, M. D., Ph. D., LL.D. (Longmans, Green, and Co., New York.)

"The Ethics of Feticide" by Austin O'Malley, M.D. (The Dolphin Press, Philadelphia.)

"Pastoral Medicine" by Alexander E. Sanford, M. D. (New Edition Revised and Enlarged by Rev. Walter M. Drum, S. J.) (Joseph F. Wagner, New York.)

"Death Real and Apparent," by Rev. Juan B. Ferreres, S. J. (B. Herder, St. Louis.)

"Notes for Catholic Nurses," by Rev. John Fletcher. (The Catholic Truth Society, London.)

"Medicina Pastoralis," by Rev. Joseph Antonelli. (Enlarged and Revised Edition.) (Fr. Pustet, Rome.)

"Summa Theologiae Moralis" (Editio Qa), by Rev. H. Noldin, S.J. (Fr. Pustet, Rome and New York.)

"Institutiones Theologiae Moralis" (Editio Nona), by Rev. Eduardus Genicot, S.J. (Alb. Dewit, Brussels.)

"Compendium Theologiae Moralis" (Editio Vicesima Octava), by Rev. Aloysius Sabetti, S. J. and Rev. Timothy Barrett, S.J. (Frederick Pustet Co., Inc., New York and Cincinnati.)

"The Principles and Practice of Obstetrics," by Joseph B. De Lee, A.M., M.D., Professor of Obstetrics at the Northwestern University Medical School. (W. B. Saunders Company, Philadelphia.)

"The Practice of Obstetrics" (Fifth Edition Revised), by J. Clifton Edgar, Professor of Obstetrics

and Clinical Midwifery in the Cornell University Medical School. (P. Blakiston's Son & Co., Philadelphia.)

"Obstetrics" (Second Enlarged and Revised Edition), by J. Whitridge Williams, Professor of Obstetrics, Johns Hopkins University. (D. Appleton and Co., New York and London.)

"Operative Obstetrics," by Edward P. Davis, A.M., M.D., Professor of Obstetrics, Jefferson Medical College. (W. B. Saunders Company, Philadelphia.)

MORAL PROBLEMS IN HOSPITAL PRACTICE

PART I

ABORTION

Question 1: What is abortion?

Answer: Abortion is the expulsion of the human fetus, before it is viable, from the uterus of the mother.

(See Part II, p. 23)

VIABILITY

Question 2: When is the human fetus viable?

Answer: The human fetus is viable when it is capable of living outside of the uterus.

In hospitals properly equipped to care for the life of the newly born, the human fetus may be regarded as viable at the end of the sixth calendar month, or, to be exact, at the end of the twenty-sixth week of gestation. But in private medical practice, under ordinary conditions, it is not lawful to regard the fetus as viable before the end of the twenty-eighth week of gestation.

(See Part II, p. 24 to p. 27)

PREMATURE DELIVERY

Question 3: At what period is it lawful to effect

premature delivery of the fetus as a means of saving the mother's life?

Answer: It is lawful to effect premature delivery of the fetus as a means of saving the mother's life, only when the fetus is viable; that is, at the end of the twenty-sixth week of gestation in hospitals properly equipped to care for the newly-born; but in private medical practice, under the ordinary conditions, it is not lawful to effect premature delivery before the end of the twenty-eighth week of gestation.

(See Part II, pp. 27—28)

Premature Delivery When in Doubt as to Date at Which Pregnancy Began

Question 4: Since it is practically impossible, in some cases, to determine the date at which pregnancy has begun, if a doctor has an honest doubt as to whether the fetus is in the 25th or 26th week, is it lawful for him to effect premature delivery at this time, if he judges that such a course is necessary to save the life of the mother?

Answer: Yes, it is lawful in hospitals properly equipped.

(See Part II, pp. 27—28)

Direct Abortion

Question 5: What is direct abortion?

Answer: Direct abortion is that which is procured as an end, or as a means to an end.

(See Part II, p. 28)

Direct Abortion Unlawful

Question 6: Is it ever lawful for any purpose whatever to procure direct abortion?

Answer: No, it is never lawful.

(See Part II, p. 28 to p. 56)

Medical or Therapeutic Abortion

Question 7: Is medical or therapeutic abortion ever lawful?

Answer: No, it is never lawful.

(See Part II, p. 56 to p. 60)

Removal of Inviable Fetus

Question 8: If it is morally certain that a pregnant mother and her unborn child will both die if the pregnancy is allowed to take its course, but if, at the same time, the attending physician is morally certain that he can save the mother's life by removing the inviable fetus, is it lawful for him to do so?

Answer: No, it is not. Such a removal of the fetus would be direct abortion.

(See Part II, p. 60)

Curettage of Pregnant Uterus in Cases of Threatened or Inevitable Abortion

Question 9: In cases of either threatened or inevitable abortion, is curettage of the pregnant uterus lawful before the fetus is viable, when such a procedure is deemed necessary to save the life of the mother?

Answer: No, it is not lawful, because such a procedure is direct abortion.

(See Part II, pp. 61 and 62)

Curettage of the Pregnant Uterus Before the Fetus is Viable

Question 10: Are there any conditions that can morally justify the curettement of the pregnant uterus before the fetus is viable?

Answer: No, there are no such conditions.

(See Part II, p. 62)

Incarceration of Pregnant Uterus

Question 11: When the pregnant uterus becomes immovably locked in the upper strait, the fetus being not yet viable, and the attending physician, after trying other expedients, is convinced that the only means by which the uterus may be turned and replaced is to pierce the amnion, and thereby empty the pregnant uterus,—is it lawful for him to do so in order to save the life of the mother?

Answer: No, it is not lawful. Such an emptying of the uterus is direct abortion.

(See Part II, p. 62 to p. 65)

Pernicious Vomiting

(*Hyperemesis Gravidarum*)

Question 12: In a case of pernicious vomiting, which endangers the mother's life, is it ever lawful, as a means of saving the mother's life, to empty the uterus before the fetus is viable?

Answer: No, it is never lawful, for such a procedure would be direct abortion.

(See Part II, p. 65 to p. 68)

Eclampsia

Question 13: In a case of eclampsia, which endangers the mother's life, is it ever lawful, as a means of saving the mother's life, to empty the uterus before the fetus is viable?

Answer: No, it is never lawful, for such a procedure would be direct abortion.

(See Part II, p. 68 to p. 72)

Hydramnios

Question 14: In an acute case of hydramnios, in which the mother's life is endangered to a degree where expectant treatment could not save her, is it

ever lawful to rupture the membranes before the child is viable, and thereby induce abortion in order to save the mother's life?

Answer: No, it is never lawful to rupture the membranes under such conditions, because to do so would be to procure direct abortion.

(See Part II, p. 72)

Premature Rupture of Membranes

Question 15: If the membranes rupture before the fetus is viable, is it lawful to administer drugs to bring on abortion?

Answer: No, it is not lawful under the circumstances to procure abortion, either by the administering of drugs, or by any other means, because to do so would be to procure direct abortion.

(See Part II, p. 73)

Hemorrhage

(Placenta Praevia)

Question 16: In a case where hemorrhage occurs from *placenta praevia* and endangers the mother's life, before the fetus is viable, is it ever lawful to empty the uterus, as a means of checking the hemorrhage and thereby saving the mother?

Answer: No, it is never lawful to empty the uterus in such a case, because to do so would be to procure direct abortion.

(See Part II, p. 73 to p. 78)

Direct Killing of the Fetus: Embryotomy, Craniotomy, Etc.

Question 17: Is it ever lawful to perform embryotomy, craniotomy, or any other operation directly destructive of the life of the fetus, whether the fetus is viable or inviable?

Answer: No, it is never lawful.

(See Part II, p. 79 to 96)

Indirect Abortion

Question 18: What is indirect abortion?

Answer: Indirect abortion is abortion that results from the employment of means that are used for some other end than the expulsion of the fetus, although it is foreseen that these means may unintentionally cause the expulsion of the fetus. Abortion therefore is indirect, when it is not made the end either of the operator or of the operation, or when it is not made a means of achieving even the ultimate end of the operator or of the operation.

(See Part II, p. 96 to p. 105)

Indirect Killing

Question 19: When is killing indirect?

Answer: Killing is indirect, when it is neither intended as an end for its own sake, nor chosen as a means toward an end, but is attached as a circumstance to the end or the means. ("The Ethics of Medical Homicide," p. 15.)

(See Part II, p. 97 to p. 105)

Medical Treatment or Surgical Operation that Might Result in Indirect Abortion or Indirect Killing of the Fetus

Question 20: Is it lawful under any circumstances to administer a treatment to a pregnant woman, or to perform an operation upon her, that might cause an abortion, or might result in a killing of the fetus?

Answer: Yes, it is lawful, when certain conditions are verified, which conditions make either the abortion indirect, or the killing indirect.

These conditions are stated and explained in Part II, pages 98 to 101.

(See Part II, p. 100 to p. 105)

Removal of Appendix, Gall Bladder, or Some Other Organ, During Pregnancy

Question 21: If, during pregnancy, before the fetus is viable, a pregnant woman's life becomes endangered by a disease of the appendix, or of the gall bladder, or of some other organ, is it lawful to remove such an organ, provided the removal does not in-

volve a direct attack upon the life of the fetus, but may result either in indirect abortion or in indirectly causing the death of the fetus?

Answer: Yes, it is lawful.

(See Part II, p. 105)

A Medical Treatment likely to Cause Abortion, When Woman's Life is not in Danger

Question 22: If during pregnancy, before the fetus is viable, a woman is suffering from an illness that does not endanger her life, is it lawful, in seeking to relieve such an illness, to administer a treatment that will probably cause an abortion, or will probably result indirectly in the death of the fetus?

Answer: No, it is not lawful.

(See Part II, p. 106, and p. 96 to p. 101)

A Medical Treatment, not Likely to Cause Abortion, When Woman's Life is not in Danger

Question 23: If during pregnancy, before the fetus is viable, a woman is suffering from an illness that does not endanger her life, is it lawful, in seeking to relieve such an illness, to administer a treatment that involves only a slight risk of causing an abortion, or of indirectly resulting in the death of the fetus?

Answer: Yes, it is lawful.

(See Part II, pp. 106 and 107, and p. 96 to p. 101)

THREATENED ABORTION—USE OF THE TAMPON

Question 24: In case of threatened abortion, in which the hemorrhage does not actually endanger the woman's life, is it lawful to tampon the uterine cervix and the vagina?

Answer: No, it is not lawful.

(See Part II, p. 107 to p. 110, and p. 96 to p. 101)

INEVITABLE ABORTION—USE OF THE TAMPON

Question 25: In a case of inevitable abortion, in which the hemorrhage is so profuse as to endanger the woman's life, is it lawful to tampon the uterine cervix and the vagina, in order to check the hemorrhage?

Answer: Yes, it is lawful.

(See Part II, p. 110 to p. 112, and p. 96 to p. 101)

USE OF MORPHINE IN THREATENED ABORTION

Question 26: In a case of threatened abortion, is the cautious administration of morphine lawful, even though its use involves a real danger to the fetus?

Answer: Yes, it is lawful.

(See Part II, p. 112 to p. 114, and p. 96 to p. 101)

LARGE DOSES OF MORPHINE DURING PREGNANCY

Question 27: Is it lawful to administer large doses

of morphine during pregnancy for the relief of physical pain that does not involve a real danger to the mother or the fetus?

Answer: No, it is not lawful.

(See Part II, p. 114, and p. 96 to p. 101)

Administration of Quinine for Malaria During Pregnancy

Question 28: Is it lawful to administer quinine, in sufficient quantities to counteract a malarial infection that develops during pregnancy, before the fetus is viable?

Answer: Yes, it is lawful.

(See Part II, p. 115 and 116, and p. 96 to p. 101)

Administration of Quinine During Pregnancy, in the Absence of Malarial Infection

Question 29: In the absence of malarial infection, is it lawful to administer large doses of quinine, during pregnancy, before the fetus is viable?

Answer: No, it is not lawful.

(See Part II, p. 116, and p. 96 to p. 101)

Removal of Pregnant Uterus in Case of Myoma

Question 30: If, during pregnancy, tumors form

in the muscular tissue of the uterus, and grow to such an extent, before the fetus is viable, as to endanger the life of the mother, is it lawful to excise totally the impregnated uterus, if this is the only means left of saving the mother's life?

Answer: Yes, it is lawful.

(See Part II, p. 117 to p. 119, and p. 96 to p. 101)

Myomata of Pregnant Uterus, not Endangering the Mother's Life

Question 31: If, during pregnancy, myomata are discovered in the pregnant uterus, but their presence will not endanger the mother's life before the fetus is viable, is it lawful to excise the impregnated uterus before the term of viability?

Answer: No, it is not lawful.

(See Part II, p. 119 and p. 96 to p. 101)

Carcinoma of Pregnant Uterus

Question 32: If carcinoma of the uterus develops during pregnancy, and the mother's life is thereby endangered, before the fetus is viable, is it lawful to excise totally the pregnant uterus, if the physician judges that such a course will save the mother's life?

Answer: Yes, it is lawful.

(See Part II, p. 120 to p. 124 and p. 96 to p. 101)

Accidental Hemorrhage

Abruptio Placentae

Question 33: In a case of severe hemorrhage, due to the premature complete separation of the normally implanted placenta, occurring before the fetus is viable, is it lawful to empty the uterus?

Answer: Yes, it is lawful.

(See Part II, p. 125 to p. 129)

Removal of Inviable Ectopic Fetus

Question 34: In a case of ectopic pregnancy, in which the presence of the fetus is regarded as endangering the mother's life, is it lawful to remove an inviable ectopic fetus?

Answer: No, it is not lawful.

(See Part II, p. 135)

Unruptured Tubal Pregnancy

Question 35: In a case of ectopic pregnancy, which has been diagnosed as a case of unruptured tubal pregnancy, is it lawful, before the term of viability, to remove the unruptured tube with the living fetus, as a means of forestalling the danger to the mother's life, upon the rupture of the tube?

Answer: No, it is not lawful.

(See Part II, p. 135)

Inviable Ectopic Fetus Discovered During Abdominal Operation

Question 36: If a surgeon, operating for appendicitis, or for the purpose of curing some other disease not directly proceeding from the pregnancy, discovers an ectopic fetus not yet viable, is it lawful for him to remove it?

Answer: No, it is not lawful.

(See Part II, p. 136)

Viable Ectopic Fetus Discovered During Abdominal Operation

Question 37: If a surgeon, operating for appendicitis, or for the purpose of curing some other disease not directly proceeding from the pregnancy, discovers an ectopic fetus that is viable, but that has not reached the full term of gestation, is it lawful for him to remove it?

Answer: Yes, it is lawful.

(See Part II, p. 136)

Doubtful Case Concerning an Enlarged Tube

Question 38: If a surgeon, operating for appendicitis, or for the purpose of curing some other disease not directly proceeding from the pregnancy, discovers an enlarged Fallopian tube, and he finds it impossible

to determine whether the enlargement is due to an inviable ectopic fetus, or a hematosalpinx, or some similar cause, is it lawful for him to remove the tube, if he judges that its condition constitutes a danger to the woman's life?

Answer: Yes, it is lawful.

(See Part II, p. 137)

Ruptured Tubal Pregnancy

Question 39: In a case of ruptured tubal pregnancy with hemorrhage, which endangers the mother's life, is it lawful to perform celiotomy, ligate the mother's arteries, and remove the tube and the fetus?

Answer: Yes, it is lawful, whether the fetus is viable or not.

(See Part II, p. 138 to p. 140)

Diagnosis Uncertain as to Ectopic Gestation or Pelvic Tumor

Question 40: A surgeon, after consultation, does not know whether the growth in a woman's pelvis is a tumor, or a sac containing an extra-uterine fetus. May he operate at once, or is he obliged to put off the operation until a time when certain signs of pregnancy should be present to establish a diagnosis of gestation, or the lack of these signs to establish a diagnosis of tumor?

Answer: The question, as proposed, requires a double answer.

(1) If under the circumstances mentioned in the question, the woman's life is actually in danger, the surgeon may operate.

(2) If her life is not actually in danger, he must defer the operation until such time as he will be able to make a differential diagnosis between ectopic pregnancy and tumor.

(See Part II, p. 141 to p. 142)

Operation in Case of Uncertain Diagnosis of Ectopic Pregnancy

Question 41: A surgeon, after consultation, is unable to determine whether a growth in a woman's pelvis is a malignant tumor, or a sac containing an extra-uterine fetus, but he proceeds at once to perform celiotomy, and after he opens the abdomen, he finds a sac containing a living inviable ectopic fetus instead of a tumor,—is it lawful for him to remove the sac with the living ectopic fetus?

Answer: No, it is not lawful.

(See Part II, p. 142)

Uncertainty Whether Ectopic Fetus is Living or Dead

Question 42: In the event a surgeon diagnoses a

case of ectopic gestation, but is unable to determine whether the fetus is alive or dead, is he justified in operating without further delay?

Answer: No, he is not justified.

(See Part II, p. 143 to 144)

Grave Mutilation

Question 43: What is a grave mutilation?

Answer: A grave mutilation may be defined as one that results either from the removal of a distinct member of the human body, or in "the inhibition of the function of a distinct organ through a wound."

(See Part II, p. 148)

Lawful Grave Mutilation

Question 44: Is it ever lawful to permit a grave mutilation of the human body?

Answer: Yes, it is lawful, whenever such a procedure is deemed necessary, either to avert a present danger to the life of the individual, or to restore the general health of the whole body.

(See p. 149)

Sterilization in General

Question 45: Is it ever lawful to perform a surgical operation, or to administer any treatment, in

which sterilization is directly intended, either as an end or as a means to an end?

Answer: No, it is not lawful.

(See p. 149)

Sterilization to Avert a Future Danger

Question 46: Is it ever lawful to perform any surgical operation whose immediate end and purpose is the sterilization of a man or woman, even though the ultimate purpose of the operator is to prevent a future danger to the life of the person sterilized?

Answer: No, it is never lawful.

(See Part II, p. 150 to p. 155)

Removal of Both Tubes, or Both Ovaries, or the Uterus

Question 47: If both Fallopian tubes, or both ovaries, or the uterus, are diseased to such an extent as to endanger a woman's life, or cause serious detriment to her general health, is it lawful to remove these organs?

Answer: Yes, it is lawful.

(See Part II, p. 155)

Removal of Both Tubes, or Both Ovaries, When Only One is Diseased

Question 48: When only one tube, or one ovary,

is so diseased as to require removal, is it lawful at the same time to remove the undiseased tube, or ovary, in order to forestall future infection that would render another serious operation necessary?

Answer: No, it is not lawful.

(See Part II, p. 156 to p. 161)

Removal of an Infected Uterus

Question 49: If, at the time a cesarean section is performed, the uterus gives evidence of being infected, is it lawful to remove the infected uterus?

Answer: Yes, it is lawful.

(See Part II, p. 161 to 164)

Removal of an Uninfected Uterus

Question 50: If, at the time a cesarean section is performed, the uterus gives no evidence of being actually infected, is it lawful to remove the uterus in order to forestall the danger of infection?

Answer: No, it is not lawful.

(See Part II, p. 164)

Removal of Uterus When Both Tubes and Both Ovaries are Removed

Question 51: If both Fallopian tubes and both ovaries are so diseased as to require removal, is it

lawful at such a time to remove the uterus, even though it gives no evidence of infection?

Answer: Yes, it is lawful.

(See Part II, p. 164)

Removal of Appendix not Diseased

Question 52: While operating in the pelvic cavity for some reason other than appendicitis, is it lawful for a surgeon to remove an apparently healthy appendix, if he judges that unless he does remove it, it will form adhesions, and thereby render another abdominal operation necessary in the future?

Answer: Yes, it is lawful to remove it.

(See Part II, p. 165 and 166)

Twilight Sleep

Question 53: What are the moral aspects of the use of "Twilight Sleep" during labor?

Answer: The regular use of "Twilight Sleep" during labor is not morally justifiable, when judged by the moral principles that should govern medical practice.

(See Part II, p. 167 to p. 174)

Right to Question Surgeon in Course of Operation

Question 54: Has a Sister in charge of an operating

room the right to question a surgeon as to the purpose of the work he is doing in the course of an abdominal operation?

Answer: Yes, she has not only a right but a duty to question him, if she has reasonable grounds to suspect that he is doing something that is not morally lawful.

(See Part II, p. 174)

Right to Tell Surgeon not to Remove Ovaries or Uterus

Question 55: Has a Sister in charge of an operating room the right to tell a surgeon not to remove ovaries, or do a complete hysterectomy?

Answer: Ordinarily the Sister has not the right to do so. If the ovaries, tubes or uterus are at all diseased, the surgeon should be the sole judge of what should be done; but if a Sister has good grounds for suspecting that a surgeon is removing healthy ovaries, healthy tubes, or a healthy uterus for the purpose of sterilizing a patient, she has a right to question him, and if she finds he is actually doing so, to protest against his action.

(See Part II, p. 175 and 176)

Doubt Regarding Curettage

Question 56: If curettage is slated on the board,

how is a Sister to know whether it is an abortion or not?

Answer: A Sister in charge of an operating-room has a right to know the nature of every operation to be performed. Therefore it should be an established rule that a surgeon should be required to state in advance the nature of the operation he is to perform, at least, as far as his diagnosis will enable him to do so.

(See Part II, p. 176)

Absence of Fetal Heart Tones as Indication for Baptism

Question 57: Is the imperceptibility of the fetal heart beat an indication to administer baptism *in utero,* as this is the case sometimes in normal labor?

Answer: Taken alone it is not a sufficient indication for baptism *in utero,* but it adds strength to any other sign that might indicate that the child's life is in danger during the course of parturition.

(See Part II, p. 176)

PART II

SECTION I

DIRECT ABORTION

In this section are treated questions involving direct abortion. Therefore it is of the highest importance to have at the outset a clear understanding of the definitions of "Abortion," "Viability" and "Direct Abortion," because a distinct understanding of the exact meaning of these terms is implied in the answer to every question from question 6 to question 16 inclusive. As the answers to all these questions involve the application of the same moral principles, these principles are stated and discussed at length under the answer to question 6. Consequently, the answer to question 6, together with all supplemental matter under it, should be taken in connection with the answer to each question, from question 7 to question 16 inclusive.

ABORTION

Question 1: What is abortion?

Answer: Abortion is the expulsion of the human fetus, before it is viable, from the uterus of the mother. It is evident that the understanding of this definition of abortion depends upon the sense in which the word

"viable" is used. Hence the reason for question 2 with its answer.

VIABILITY

Question 2: When is the human fetus viable?

Answer: The human fetus is viable, when it is capable of living outside of the uterus. The human fetus is capable of living outside of the uterus, under the ordinary conditions that prevail in private medical practice, at the end of the twenty-eighth week of gestation. Hence the recognized period of viability is the end of the seventh lunar month, or the end of the twenty-eighth week of gestation.

Upon this point Edgar writes as follows: "The period of viability is the time when the fetus can live apart from its mother, the turning-point between *partus immaturus* and *praematurus;* and this limit is generally placed at the end of the seventh lunar month, or twenty-eighth week from conception." (Edgar, p. 326.)

While the recognized period of viability is the end of the twenty-eighth week of gestation, it is possible for a fetus to live apart from its mother at the end of the sixth calendar month, or the twenty-sixth week of gestation, if it is delivered in a hospital properly equipped to care for the newly born.

Standard writers on obstetrics are unanimous in their agreement that a fetus delivered at the end of

the sixth lunar month, or the twenty-fourth week of gestation, is not sufficiently developed to live outside of the uterus.

Regarding the fetus at the end of the sixth lunar month, or the end of the twenty-fourth week, Williams writes as follows: "A fetus born at the end of the sixth lunar month will attempt to breathe and move its limbs, but always perishes within a short time." (Williams, p. 146.)

"A fetus born at the end of the sixth lunar month," says Edgar, "might live for fifteen days, but it would finally die from insufficient air supply, for the finer air-passages are yet undeveloped. There would also be imperfect assimilation of food and rapid loss of heat." (Edgar, p. 72.)

"Since the respiratory, digestive, and assimilative organs are undeveloped, at the end of the sixth lunar month," writes De Lee, "no artificial means will preserve these fetuses from congelation and starvation." (De Lee, p. 56.)

From the foregoing, therefore, it is evident that the fetus at the end of the sixth lunar month, or the twenty-fourth week of gestation, is not viable.

A small number of children, born under favorable conditions, between the end of the twenty-fourth week, and the end of the twenty-sixth week, have been raised by very special care, but the percentage of these children raised has been so small, that is it not morally safe to regard a fetus as viable before the end of the

twenty-sixth week of gestation, even when it is delivered under the most favorable conditions.

From all that has been said above, three conclusions should be drawn.

First, the fetus is not viable before the end of the twenty-sixth week of gestation.

Second, in hospitals properly equipped, that is, where artificial incubation and other special facilities are provided to care for the life of the newly born, it is lawful to consider the fetus as viable at the end of the twenty-sixth week of gestation. However, it should be strictly understood that there is always a danger to the life of a fetus delivered at the end of the twenty-sixth week, even under the most favorable conditions, and consequently, nothing but a real danger to the mother's life, from the continuance of the pregnancy, can morally justify the premature delivery of a fetus at the end of the twenty-sixth week of gestation.

Third, in private medical practice, it is not lawful to regard a fetus, delivered under ordinary conditions, as viable before the end of the twenty-eighth week of gestation; because a fetus delivered under ordinary conditions, where special facilities to care for the life of the newly born are lacking, has practically no chance to survive, and hence, under the circumstances mentioned, it is not morally lawful to deliver such a fetus before the end of the twenty-eighth week of gestation.

Premature Delivery

Question 3: At what period is it lawful to effect premature delivery of the fetus, as a means of saving the mother's life?

Answer: It is lawful to effect premature delivery of the fetus, as a means of saving the mother's life, only when the fetus is viable, that is, at the end of the twenty-sixth week of gestation, in hospitals properly equipped to care for the newly-born; but in private medical practice, under the ordinary conditions, it is not lawful to effect premature delivery before the end of the twenty-eighth week of gestation.

Premature delivery, therefore, strictly understood, means delivery after the fetus has reached the term of viability, but before it has completed the normal term of gestation.

Premature Delivery When in Doubt as to Date at Which Pregnancy Began

Question 4: Since it is practically impossible, in some cases, to determine the date at which pregnancy has begun, if a doctor has an honest doubt as to whether the fetus is in its 25th or 26th week, is it lawful for him to effect premature delivery at this time, in a hospital properly equipped to care for the newly born, if he judges that such a course is necessary to save the life of the mother?

Answer: Yes, it is lawful. Under the circum-

stances mentioned in the question, the danger to the mother is a present and certain danger, while the added danger to the fetus from the probability of delivering it before the end of the 26th week is a doubtful danger, since the term of the pregnancy itself is doubtful; therefore the mother is entitled to the benefit of the doubt. In connection with this conclusion it should be borne in mind that, in a limited number of cases, children actually delivered during the 25th week of gestation have been raised with expert care.

It should also be noted that the answer to the question applies to hospital practice.

Direct Abortion

Question 5: What is direct abortion?

Answer: Direct abortion is that which is procured as an end, or as a means to an end.

From the foregoing definition, abortion may be direct in either of two ways.

First, abortion is direct, when it is procured as the immediate end or object of both the operator and the operation.

Secondly, abortion is direct, when it is procured as a means for the attainment of some end.

Direct Abortion Unlawful

Question 6: Is it ever lawful, for any purpose whatever, to procure direct abortion?

Answer: No, it is never lawful, because it is an act that is intrinsically immoral, and no ultimate purpose however good can justify such an act.

To procure direct abortion is an act that is intrinsically immoral, because it is an act by which the fetus is directly, and just as effectively, killed, as by the act of crushing the head of the living child in craniotomy.

Abortion has been defined as "the expulsion of the human fetus, before it is viable, from the uterus of the mother." When this expulsion is procured, either as an end, or as a means to an end, it is said to be direct abortion.

While in the uterus, before the term of viability has been reached, the fetus is dependent for its life upon its union with the maternal system by means of the placenta and umbilical cord. This union, essential to the life of the child, is completely destroyed by direct abortion, and, consequently, direct abortion is an act that directly destroys the life of the fetus and is therefore intrinsically immoral.

Moral Principles Governing Direct Abortion

Owing to the importance of the subject, and to the many questions to which it gives rise, it is of the utmost importance to state clearly the moral principles that govern direct abortion, and to discuss at length the arguments that are most commonly advanced to justify it.

The moral principles which determine the morality of direct abortion may be reduced to two:

First, "Thou shalt not kill."

Second, "Evil must not be done that good may come from it"; or, in other words, "A good end does not justify an evil means."

The first, "Thou shalt not kill," is not only a divine precept, but it is also a mandate of the natural law.

The second, "Evil must not be done that good may come from it," is a fundamental principle of ethics. In the statement of this principle the word "evil" is used in the sense of "moral evil." To deny the validity of this principle by asserting that it is ever lawful to do moral evil that good may come from it, is the same as to deny that there is any such thing as a fixed and immutable basis of morality.

As a direct, necessary, and irrefutable consequence of the two principles stated above, the Church has drawn the conclusion that it is never lawful to procure direct abortion.

From the first moment of its conception, the human fetus is a human being, and therefore from the first moment of conception, it has an inalienable right to its life. The mother has absolutely no dominion over its life, she is only its guardian. God alone has dominion over the life of the human fetus, and He has made its right to life sacred and inviolable, both by the natural law and by divine precept.

The teaching of the Church embodied in the sentence,

"It is never lawful to procure direct abortion," is amplified and explained by Catholic authors who have written upon the subject of abortion.

In an article upon the "Ethics of Feticide," Dr. Austin O'Malley writes as follows:

"When we began to vegetate, our life began; we had a soul; and this as soon as the pronucleus of the spermatozoon fused with the pronucleus of the ovum, and made the first segmentation-nucleus. Before the first fission of that segmentation nucleus was completed into two distinct cells the soul was present, for that fission was independent life; and any life is impossible without a soul, or, what is the same thing, a vital principle. Since, moreover, the soul with the body is man, and since the process of vegetation in our present state is identical with that first cell-fission, this splitting primordial cell is a human being. The active primordial cell in this stage is as much a complete phase of human life as are the body and soul of a person at puberty, or at adult age. Indeed, that cell with its vital principle at this stage of the process of human life is the only normal, possible, condition of the human body beginning life. This splitting cell has an absolutely independent life; it is feeding itself from the ovum, as later it will feed itself from the placental blood, and later still from the maternal milk, and yet later with a knife and fork. The ovum is only a necessary container, as the womb will be later; essential but extraneous. . . .

"We are to bear in mind, then, that the human embryo in the womb, no matter how young it may be, is as much a child as a week-old babe; and, because it is a human being, it has all the rights of a human being to its life. The opinion formerly followed in the civil law, that life begins with quickening, is utterly unscientific and immoral. At quickening, the child is four or five months old. In the human fetus, three days old, examined by Peters, there were already thousands of cells in one cross-section, and millions in the whole embryo.

"In any case, therefore, there is no period during pregnancy, capable of diagnosis as such, where we have not a new human life to deal with." ("Ethics of Feticide," pages 3 and 4.)

Dr. L. Charles de Boisliniere, Professor Emeritus of Obstetrics in St. Louis Medical College, and author of "Obstetric Accidents, Emergencies, and Operations," in delivering a lecture on the Moral Aspects of Craniotomy and Abortion, before the St. Louis Obstetrical and Gynecological Society, spoke as follows: "The principle once admitted that you are not justified in killing an innocent aggressor, except in self-defense, equally prohibits any interference with early gestation. From the moment of conception, the child is living. It grows and what grows has life. Therefore feticide is not permissible at any stage of utero-gestation. The killing of the defenseless fetus is sometimes done in cases of pernicious vomiting, in

cases of tubal or abdominal gestation. The killing is accomplished by electricity, injections of morphine in the amniotic sac, the puncturing of that sac, etc. This practice is altogether too easily adopted by thoughtless and unscrupulous physicians. This practice is much on the increase. Is it not time that this wanton massacre of the innocents should cease?"

"Medical Jurisprudence," by Wharton and Stillé, quotes Dr. Hodge of Pennsylvania University as follows (p. 11): "In a most mysterious manner brought into existence, how wonderful its formation! Imperfect in the first instance, nay, even invisible to the naked eye, the embryo is nevertheless endowed, at once, with the principles of vitality; and although retained in the system of its mother, it has, in a strict sense, an independent existence." Wharton and Stillé then add: "The usual impression, and one which is probably still maintained by the mass of the community, is that the embryo is perfected at the period of quickening—say the one hundred and twelfth or one hundred and twentieth day. When the mother first perceives motion, is considered the period when the fetus is animated,—when it receives its spiritual nature into union with its corporeal. These and similar suppositions are, as has been already shown, contrary to all fact, and, if it were not for the high authorities—medical, legal, and theological—in opposition, we might add, to common sense."

And these authors of "Medical Jurisprudence" con-

clude: "Where there has been as yet no judicial settlement of the immediate question, it may be reasonably contended, that to make the criminality of the offence (abortion) depend upon the fact of quickening, is as repugnant to sound morals as it is to enlightened physiology."

Upon which Father Coppens makes the following comment: "At present there seems to be no longer any authority to the contrary. But many people, and some doctors, seem to be several generations behind the times; for they still act and reason as if, in the first weeks of pregnancy, no immortal or human soul were in question." (Pp. 60, 61.)

Regardless of what opinion may be held as to the time when the human soul begins to animate the fetus, the Church has always condemned direct abortion at any stage of gestation.

Pope Sixtus V, in 1588, decreed that any one who effects the abortion of an immature fetus, either by blows, poison, drugs or potions, or tasks of hard labor imposed on pregnant women, or by any other method, however subtle or obscure it may be, is guilty of murder, and is to be punished accordingly.

While the Church has never issued a definitive decree as to the time when the human soul begins to animate the human fetus, nevertheless the mind of the Church may be said to be revealed in the decree of Sixtus V, which covers the period of gestation

from the moment of conception until the fetus is viable.

From the moment of conception, therefore, until the time of viability, direct abortion is directly destructive of the life of the human fetus.

It matters not what reasons may be advanced to justify direct abortion, it is an unjust invasion of the sacred, inviolable, and inalienable right to life of an innocent human being, and therefore the Church places it in the same category as wilful murder, which is forbidden both by the natural law and the divine precept, "Thou shalt not kill."

Analysis of Arguments Advanced to Justify Direct Abortion

(1) The "Unjust Aggressor" Argument.

This argument may be stated briefly as follows: "In certain desperate cases of pregnancy, the fetus may be regarded as an unjust aggressor upon its mother's life, and therefore as having forfeited its right to its life. In such cases it is lawful to deliver the fetus before it is viable, in order to save the mother's life."

Reply to the Argument

This argument is fully and satisfactorily answered

by Father Coppens in his work on "Moral Principles and Medical Practice," as follows:

"Now the only case in which the need of medical treatment could become a matter of discussion in jurisprudence, is the case of a mother with child. Is the child under those circumstances really an unjust aggressor? Let us study that important case with the closest attention. Let all the rays of light we have gathered so far be focused on this particular point. Can a physician be ever justified in destroying the life of a child, before or during its birth, by craniotomy or in any other manner, in order to save the mother's life, on the plea that the child is an unjust assailant of the life of its mother? Put the case in a definite shape before you. Here is a mother in the pangs of parturition. An organic defect, no matter in what shape or form, prevents delivery by the ordinary channels. All that medical skill can do to assist nature has been done. The case is desperate. Other physicians have been called in for consultation, as the civil law requires before it will tolerate extreme measures. All agree that, if no surgical operation is performed, both mother and child must die. There are the Cæsarian section, Porro operation, laparotomy, symphyseotomy, all approved by science and the moral law. But we will suppose an extreme case; namely, the circumstances are so unfavorable for any of these operations—whether owing to want of skill in the

doctors present, or for any other reason—that none can safely be attempted; any of them would be fatal to the mother.

"In this extreme case, can the doctor break the cranium of the living child, or in any way destroy its life with a view to save the mother? If three consulting physicians agree that this is the only way to save her, he will not be molested by the law courts for performing the murderous operation. But will the law of nature and of nature's God approve or allow his conduct? This is the precise question under our consideration. We have seen that the infant—a true human being, has a right to live, as well as its mother. 'All men are created equal, and have an equal right to life,' declares the first principle of our liberty. The Creator, too, as reason teaches, has a clear right to the child's life; that child may answer a very special purpose of Providence. But whether it will or not, God is the supreme and only Master of life and death, and He has laid down the strict prohibition, 'Thou shalt not kill.'

"Now comes the plea of self-defence against an unjust aggressor. If the child is such, if it unjustly attacks its mother's life, then she can destroy it to save herself, and her physician can aid the innocent against the guilty party. But can it be proved that the infant is an unjust aggressor in the case? There can be no intentional or formal guilt in the little in-

nocent babe. But can we argue that the actual situation of the child is an unjust act, unconsciously done, yet materially unjust, unlawful? Thus, if a madman would rush at me with a sharp sword, evidently intent on killing me, he may be called an unjust aggressor; though, being a raving maniac, he does not know what crime he is committing, and is formally innocent of murderous intent. Materially considered, the act is unjust, and I can defend myself lawfully as against any other unjust assailant. Such is the common teaching of moralists. But can the innocent babe be classed in the same category with the raving maniac? Why should it? It is doing nothing; it is merely passive during the whole process of parturition.

"Will any one object that the infant has no right there at all? Who put it there? The only human agents in the matter were its parents. The mother is more accountable for the unfortunate situation than the child. Certainly you could not, to save the child, directly kill the mother, treating her as an unjust assailant of her child's life. Still less can you treat the infant as an unjust assailant of its mother's life.

"The plea of self-defence against unjust aggression being thus ruled out of court in all such cases, and no other plea remaining for the craniotomist, we have established, on the clearest principles of ethics and jurisprudence, that it is never allowed directly to kill a child as a means to save its mother's life. It

would be a bad means, morally evil; and no moral evil can ever be done that good may come of it; the end cannot justify an evil means. In theory all good men agree with us that the end can never justify the means. But in practice it seems to be different with some of the medical profession."

(Rev. Charles Coppens, S. J., "Moral Principles and Medical Practice," pages 51, 52 and 53.)

(See also: "The Right to Life of the Unborn Child," pages 30 and 31, by Rev. R. van Oppenraay, S. J., D. D., and Prof. Th. M. Vlaming, M. D.— "The Ethics of Feticide" by Austin O'Malley, M. D., page 13.— "Ethics of Medical Homicide," pages 110 and 111, by Austin O'Malley, M. D.)

Let it be carefully noted that the question proposed and answered by Father Coppens is: "In an extreme case may the doctor break the cranium of the living child, or in any way destroy its life, with a view to save the mother?" This question, and its answer given above, covers all forms of DIRECT ABORTION, which is always destructive of the life of the fetus.

(2) ARGUMENT OF "MOTHER'S PRIORITY OF RIGHT TO LIFE"

This argument may be stated as follows:—

"In cases of pregnancy, where the mother's life is endangered by the presence of the inviable fetus, the mother's right to life is prior to the right to life

of the fetus, and therefore it is lawful to induce abortion as a means of saving the mother's life."

Reply to the Argument

All human beings are equal in their essential rights, and therefore there is no such thing as "priority to the right to life," which is one of the essential rights of every human being. The fetus is a human being, and hence its right to life is as sacred and inviolable as the mother's right to her life.

Father Klarmann writing upon this subject has the following:—"In the possession of the essential rights of nature, there is no priority; lest we be forced to concede, that parents, for this reason, have the right of disposition over the lives of their children at any time. This was indeed the condition among barbarous nations; but we are no longer barbarians, and the claim is preposterous. The natural rights of a human being are the same at any stage of his life, whether nascent or matured." ("Crux of Pastoral Medicine," pp. 105, 106.)

Dr. A. Pinard, Professor of Obstetrics at Paris, writing upon Therapeutic Feticide, says: "The right over the child's life and death belongs neither to the father, nor to the mother, nor to the physician." And further: "To discuss from an economical or social view-point the difference in value of the life of the mother and that of the child is simply monstrous."

(3) Argument Based on the Professional Obligation of the Physician, and on the Principle of "Choosing the Less of Two Evils"

This argument may be stated as follows:—"A physician is called to attend a desperate case of pregnancy before the fetus is viable. He immediately sees that unless he intervenes, both mother and fetus are destined to die; if he does intervene by inducing abortion, he will save the life of the mother but sacrifice that of the fetus. He decides without delay to intervene, justifying his intervention on the principle that, as a physician, he has a professional obligation to save human life by every means in his power, and, furthermore, that not only his professional obligation, but common sense dictates that of two evils he should choose the less."

Reply to the Argument

This argument rests upon two principles, which, when taken without qualification in connection with abortion, are falsely applied. It is stated that a physician has a professional obligation to save human life by every means in his power. Without qualification, this statement is a pure sophism. A physician not only has no professional obligation to use every means in his power to save human life, but he has a most sacred professional obligation to use no means

to save human life, unless that means is morally lawful. Direct abortion is intrinsically evil and therefore morally unlawful, and, consequently, a physician has no professional obligation to resort to it in order to save the mother, but he has a most positive obligation to refrain from it.

In "The Right to Life of the Unborn Child," Dr. Vlaming, replying to Prof. Treub upon this point, says: "You wrongly suppose without any proof that the means of which you speak is a lawful one. Certainly you would fall short of your duty as a physician if you neglected to use a lawful means to save the mother. But nothing obliges you—on the contrary, all that is reasonable forbids you—to adopt in your medical practice any unlawful means, even were this unlawful means a last resort. Now, abortion is of its very nature an unlawful means, even though you should have recourse to it with the noblest ulterior purpose. Thus your argument built upon the supposed moral obligation of availing yourself of an unlawful means is disposed of." (P. 29.)

The second principle on which this argument in favor of direct abortion rests, is that a physician, in bringing about direct abortion in order to save the life of the mother, is actually choosing the less of two evils. In so-called desperate cases of pregnancy, the physician finds himself face to face with one of two alternatives: unless he intervenes, both mother and fetus will die; if he intervenes and induces direct

abortion, the mother will be saved but the fetus will die. In inducing direct abortion in such a case, the physician justifies his action on the principle that in doing so, he is actually choosing the less of two evils.

This argument also rests upon a sophism, and is briefly and finally answered in "The Right to Life of the Unborn Child" as follows: "A little thought will show that under this question a great sophism lies hidden in our case. For it makes it appear as though we were dealing here with two things, both evil in one and the same sense; whereas, in reality, choice is claimed between two things, indeed both evil, but in a wholly different sense. The choice is here between letting the mother and the fetus die together, an evil only from a physical point of view, and the positive murdering of the fetus in order to save the mother, an evil from a moral point of view. Should both things be evils of the same order, that is, both only physical evils, then, of course, one ought to choose the less of the two. He who puts the question insinuates that the killing of the fetus is but a physical and not a moral evil, taking for granted the proof, which he ought to give. Consequently, as long as the insinuation is not proved, the conclusion abides that medical abortion, being a moral evil, may not be practiced to hinder the mere physical evil of the mother's death. 'One may not do evil that good may come from it.'" ("The Right to Life of the Unborn Child," pages 28 and 29.)

(4) Argument Based on the Principle, "Necessity Knows No Law"

Finally, certain physicians seek to justify medical abortion, as well as craniotomy, by the application of the principle that "Necessity knows no law."

In the "Medical Record" for July 27, 1895, writing in defence of craniotomy, Dr. Galloway says: "'Necessity knows no law'. The same law which lies at the basis of jurisprudence in this respect justifies the sacrifice of the life of one person, when actually necessary for the preservation of the life of another, when the two are reduced to such extremity that one or the other must die. This is the *'necessitas non habet legem*—necessity knows no law.'"

Reply to this Argument

On the foregoing extract, Father Coppens comments as follows: "The principle 'Necessity knows no law' has indeed a true and harmless meaning when properly understood; it means that no law is violated when a man does what he is physically necessitated to do, and that no law can compel him to do more than he can do. Thus, a disabled soldier cannot be compelled to march on with his regiment; necessity compels him to remain behind. In this sense the principle quoted is a truism; hence its universal acceptance. Applying the same principle in a wider sense, moralists agree that human

law-givers do not, and in ordinary circumstances cannot, impose obligations the fulfilment of which requires extraordinary virtue. Even God Himself does not usually exact of men the performance of positive heroic acts. But no such plea can be urged to justify acts which God forbids by the natural law. When necessity is used as a synonym for a 'very strong reason,' as it is in the plea of the craniotomist, then it is utterly false that very strong reasons for doing an act cannot be set aside by a divine law to the contrary; what is wrong in itself can never become right, even though the strongest arguments could be adduced in its favor. It would be doing wrong that good may come of it, or making the end justify the means. Such principles may be found in the code of tyrants and criminals, but should not be looked for in the code of medical jurisprudence." ("Moral Principles and Medical Practice," pages 97 and 98.)

In this connection Dr. L. Charles Boisliniere may again be quoted as follows: "But, as stated above, there never is an excuse for killing an innocent aggressor, and the temptation to the act, and its expediency, is not what the law has even called necessity. Nor is this to be regretted; for if in this case the temptation to murder, and the expediency of the deed, had been held by law as absolute defense of the deed, there would have been no guilt in the case. Happily this is not so. The plea of necessity, once admitted,

might be made the legal cloak for unbridled passions and atrocious crimes, such as the producing of abortion, etc.

"To preserve one's life is, generally speaking, a duty; but it may be the plainest duty, the highest duty, to sacrifice one's life. War is full of such instances, in which it is not man's duty to live, but to die. The Greek and Latin authors contain many examples in which the duty of dying for others is laid down in most glowing and eloquent language. 'Dulce et decorum est pro patria mori' ('It is sweet and glorious to die for one's country'), says Horace. Such was heathen ethics, and it is enough in a Christian country to teach that there is not always an absolute and unqualified necessity to preserve one's life.

"Thus, as a parallel case, is the situation of a woman in a difficult labor, when her life and that of her unborn child are in extreme danger. In this instance, it is the mother's duty to die rather than to consent to the killing of her child.

"In a subject of such delicacy and importance, I have avoided all argument based upon the doctrines of any particular religion, and considered the subject upon its purely ethical and scientific basis. I am aware that I am taking a position quite at variance with that occupied by many men influenced by former teachings and prejudice.

"I respect the honest convictions of those opposed

to the opinions presented in this paper. But it is to be hoped that thoughtful physicians will soon reconsider their views, and adopt a more just and human method of dealing with the rights of a living unborn child." ("Moral Principles and Medical Practice," pages 88, 89 and 90.)

In the "Ethics of Feticide" (p. 14), writing upon the point under consideration, Dr. O'Malley has the following: "Would it not be better that the fetus be killed than the mother should die? By no means. It might be better that the fetus should die rather than that the mother should die (apart from the question of baptism); but that is very different from killing the fetus. The first fact in the world is that justice, law, order, should be observed no matter what the cost; better that ten thousand mothers should die, than one fetus should be unjustly killed."

And further, "What is the conclusion from all this argumentation? What is the physician to do who meets a case that immediately calls for abortion, according to the common medical practice? The answer is clear enough: if he has any regard for the natural law, upon which all morality and social order rest, he unfortunately can do nothing; if he has no regard for this law, he will kill the fetus. The law seems to be hard, but nearly all law is hard to the loser; yet that fact does not abrogate the law, nor make it bad."

The Doctrine of the Church and the Natural Law

What has been said above substantially embodies the teaching of the Church upon the subject of abortion. The Church's teaching upon this point is founded, first upon the natural law which proceeds from God, the Author of nature; and secondly, upon the divine law embodied in the commandment, "Thou shalt not kill."

The natural law as established by God rests upon eternal and unchangeable principles, that irrevocably fix an immutable standard of right and wrong. The pagan philosophers of Greece and Rome recognized the universality, the immutability and the binding force of this law. In the twenty-second chapter of the third book of his work entitled, "De Re Publica," Cicero speaks of this law as follows: "Right reason is indeed a true law, which agrees with nature, is to be found with all people, constant and perpetual, whose commands urge us to duty and whose prohibitions deter us from wrong. We may neither oppose, nor alter this law, nor trespass against it, nor can it be altogether repealed. Neither the Senate nor the people can free us from this law. Nor is this law different at Rome from what it is at Athens, now such and later otherwise, but one, everlasting, unchangeable, this law rules all nations at all times, and the one God is the common Master and Commander.

He is the Originator, the Author and Giver of this law."

From the natural law flow the fundamental rights of every human individual. One of the most sacred and inalienable of these rights, is the right to life. This right is not only sacred and inalienable, but it must be held inviolable as long as it is not forfeited by unjust aggression. As has been shown, the fetus is not only not an unjust aggressor, but it is not an aggressor in any sense, and therefore to invade its right to life, even to save the mother, is an act of the highest injustice under the natural law, and therefore it is an act that is intrinsically immoral. An act that is intrinsically immoral is never justifiable, no matter what reasons may be alleged to justify its commission.

The unalterable conclusion, therefore, of all that has been said is, that direct abortion is intrinsically immoral, and for this reason it has at all times been forbidden by the Church.

Not only is the teaching of the Church upon abortion rejected by many members of the medical profession, but the Church in consequence of this teaching is not unfrequently accused of narrowness and even cruelty. It may be remarked, however, that it is one thing to charge the Church with narrowness and cruelty, and it is quite another thing to prove the charge by an appeal to the principles of sound morality

and sound philosophy. Before the charge of narrowness and cruelty may be made valid against the Church, it will be necessary to prove that the natural law established by the Creator carries with it no binding force whatever, that there is no such thing as an immutable standard of right and wrong, and, consequently, there is no such thing as the intrinsic morality of human acts. Until these things are proved, the teaching of the Church will rest secure against the unjustified attacks of its opponents upon this point.

Teaching Prevalent in Many Medical Schools

The teaching prevalent in many medical schools is, that whenever the presence of an inviable fetus endangers the mother's life, it is to be treated as a negligible quantity. As a result of this teaching, nearly all the leading works upon the theory and practice of obstetrics unhesitatingly recommend the procuring of abortion, when this is regarded as the necessary means to save the mother's life. Such abortion is called medical or therapeutic abortion.

These same schools that teach and advocate the practice of therapeutic abortion as a means of saving the mother's life, most loudly condemn abortion that is procured to save a mother's reputation. Such abortion is proclaimed by these schools to be criminal

abortion, and is placed in the same category as wilful murder.

Upon the subject of criminal abortion, Dr. Hodge of Philadelphia, in delivering a lecture to the medical students of the University of Pennsylvania, spoke as follows:

"We blush while we record the fact that, in this country, in our cities and towns, in this city where literature, science, morality, and Christianity are supposed to have so much influence; where all the domestic and social virtues are reported as being in full and delightful exercise; even here, individuals, male and female, exist, who are continually imbruing their hands and consciences in the blood of unborn infants; yea, even medical men are to be found who, for some trifling pecuniary recompense, will poison the fountains of life, or forcibly induce labor, to the certain destruction of the fetus and not infrequently of the parent.

"So low, gentlemen, is the moral sense of the community on this subject, so ignorant are the greater number of individuals, that even mothers, in many instances, shrink not from the commission of this crime, but will voluntarily destroy their own progeny, in violation of every natural sentiment and in opposition to the laws of God and man. Perhaps there are few individuals in extensive practice who have not had frequent applications made to them by the fathers and mothers of unborn infants (respectable

and polite in their general appearance and manners) to destroy the fruit of illicit pleasure, under the vain hope of preserving their reputation by this unnatural and guilty sacrifice.

"Married women, also, from the fear of labor, from indisposition to have the care, the expense, or the trouble of children, or some other motive equally trifling and degrading, have solicited that the embryo should be destroyed by their medical attendant. And when such individuals are informed of the nature of the transaction, there is an expression of real or pretended surprise that any one should deem that act improper, much more, guilty; nay, in spite even of the solemn warnings of the physician, they will resort to the debased and murderous charlatan, who for a piece of silver, will annihilate the life of the fetus, and endanger even that of its ignorant or guilty mother.

"This low estimate of the importance of fetal life is by no means restricted to the ignorant or the lower classes of society. Educated, refined, and fashionable women, yea, in many instances, women whose lives are in other respects without reproach—mothers who are devoted with an ardent and self-denying affection to the children who already constitute the family—are perfectly indifferent concerning the fetus *in utero*. They seem not to realize that the being within them is indeed animate, that it is in verity a human being, body and spirit; that it is of importance; that its

value is inestimable, having reference to this world and the next. Hence they in every way neglect its interests. They eat and drink, they walk and ride, they will practice no self-restraint, but will indulge every caprice, every passion, utterly regardless of the unseen, unloved embryo. . . .

"These facts are horrible, but they are too frequent and too true; often, very often, must all the eloquence and all the authority of the practitioner be employed; often he must, as it were, grasp the conscience of his weak and erring patient, and let her know, in language not to be misunderstood, that she is responsible to her Creator for the life of the being within her." (Wharton and Stillé's "Medical Jurisprudence," Parturition, p. 92. Quoted by Father Coppens in "Moral Principles and Medical Practice," pp. 73, 74 and 75)

It is well to note in this quotation the emphatic terms in which Dr. Hodge speaks of criminal abortion: "Individuals, male and female, exist who are continually imbruing their hands and consciences in the blood of unborn infants"; "even mothers, in many instances, shrink not from the commission of this crime, but will voluntarily destroy their own progeny, in violation of every natural sentiment and in opposition to the laws of God and man"; "they (mothers) seem not to realize that the being within them is indeed animate, that it is in verity a human being, body and spirit; that its value is inestimable, having reference to this world and the next."

These are strong terms indeed, and here the question naturally suggests itself: on what fundamental principle of ethics do medical schools base their teaching that it is wilful murder to kill a fetus to save a mother's reputation, and that it is mere therapeutics to kill a fetus to save a mother's life? The answer to this is a simple one. Such teaching does not rest upon any fundamental principle of ethics, but solely and entirely upon the principle of expediency. All the arguments advanced to justify therapeutic or medical abortion proceed wholly from sentiment, and are based solely upon expediency.

The advocates of medical or therapeutic abortion imply by their doctrine that the fetus has no inherent and inviolable right to its life, but derives its right to life wholly from an adventitious condition of its mother. Such a doctrine is not only contrary to Christian morality, but is also subversive of the fundamental principles of ethics.

In this connection Dr. O'Malley writes as follows: "The assertion that an undeveloped fetus in the womb is not as valuable as the mother of a family, is beside the question, and in certain vital distinctions it is untrue. Any human life, as such, whether in a fetus or an adult, is as valuable as another, inasmuch as no one but God has any authority to destroy it, except when it has lost its right to existence through culpable action. Secondly, the quality of motherhood is an accidental addition to a mother's life, not sub-

stantial, as is life itself. This quality of motherhood does not create any juridic imbalance of values which justifies the destruction of the rights inherent in the fetus. That the fetus may not be able to enjoy these rights if the mother dies is, again, an irrelevant consideration. There is no question of a comparison of values. A life is a life, whether in mother or fetus, and the destruction of an innocent life by any one except its creator, God, is essentially an evil thing, like blasphemy. An innocent fetus an hour old may not be killed to save the lives of all the mothers in the world. Insisting on such comparisons supposes ignorance and sentimental opposition to truth. It is a good deed to save a mother's life; but such saving by killing an innocent human being ceases to be good and becomes indescribably evil, an enormous subversion of the order of the natural law, as it is a usurpation of the dominion over life possessed by God alone." ("The Ethics of Medical Homicide and Mutilation," page 111.)

Direct medical abortion, therefore, is never justifiable, and the Church teaches there is no specific difference between direct medical abortion and criminal abortion.

Conclusion

In conclusion, a brief synopsis of what has been written above may be set forth, in an extract from

an article on Abortion written by Father Coppens for the Catholic Encyclopedia. It runs as follows: "While the medical profession is striving, for scientific reasons, to diminish the practice of abortion, it is evident that the determination of what is right or wrong in human conduct belongs to the science of ethics and the teaching of religious authority. Both of these declare the Divine law, 'Thou shalt not kill.' The embryonic child, as seen above, has a human soul; and therefore is a man from the time of its conception; therefore it has an equal right to life with its mother; therefore neither the mother, nor medical practitioner, nor any human being whatever can lawfully take that life away. The State cannot give such a right to the physician; for it has not itself the right to put an innocent person to death. No matter how desirable it might seem to be at times to save the life of the mother, common sense teaches, and all nations accept the maxim, that 'evil is never to be done that good may come of it'; or, which is the same thing, that 'a good end cannot justify a bad means.'"

Medical or Therapeutic Abortion

Question 7: Is medical or therapeutic abortion ever lawful?

Answer: No, it is never lawful.

Medical or therapeutic abortion is defined by Dorland as "abortion induced to save the life of the

mother." It is in this sense that the term is used in the question. Since medical or therapeutic abortion, as defined by Dorland, is always direct abortion, it is never lawful.

It matters not whether abortion be called medical, therapeutic, or by any other name, if it is direct abortion, it is intrinsically immoral and therefore unlawful.

De Lee summarizes the general teaching of medical works upon the subject of therapeutic abortion as follows: "Therapeutic abortion is rarely indicated, and lately our general therapy has improved so much that few affections justify its performance. (1) Contracted pelvis with a *conjugata vera* below 6 cm., mentioned by Soranus of Ephesus in the second century A. D., and by Cooper in 1772, to avoid the terrific mortality of the cæsarean section. Nowadays with the safety of cæsarean section, the accoucheur should refuse to perform abortion for this indication unless there are other scientific reasons, e. g., heart, lung, or kidney disease. (2) Hyperemesis gravidarum and other forms of toxemia. Without doubt, here is a real indication for abortion, but a restricted one. In cases of toxemic vomiting, with evidences of the real involvement of the structure of the liver and kidneys, one should not wait too long before emptying the uterus. (3) Incarceration of the retroflexed gravid uterus is usually better treated by laparotomy. (4) Advancing tuberculosis, as shown by loss of weight, evening fever, hemoptysis, etc. Most of

the authorities believe that the progress, while not always stayed, is rendered less fulminant by interrupting pregnancy. A combination of hyperemesis gravidarum and tuberculosis is a positive indication of abortion, as also in tubercular laryngitis. (5) Heart disease is only an indication when the muscle is badly inefficient, as advanced myocarditis and discompensation. (6) Diabetes and other constitutional diseases, as under induced labor. (7) Diseases of the kidneys, especially if complicated by retinitis. (8) Other diseases which seriously jeopardize the mother, as Basedow's disease, leukemia, pernicious anemia, chorea, etc. (9) Diseases of the ovum—polyhydramnion, hydatidiform mole." (De Lee, p. 1018.)

Such is the common teaching of works on obstetrics. With reference to the nine indications for therapeutic abortion, it must be most positively stated that not a single one of the nine ever makes it morally justifiable to remove an inviable living fetus from the pregnant uterus.

On examining these nine indications, it will be noted that in nearly every instance the disease that is given as a justification for therapeutic abortion, has its origin in the mother and not in the fetus. Every woman entering the married state, must accept the risks and dangers incidental to that state. Therefore when a married woman with a contracted pelvis, or afflicted with toxemia, heart disease, diabetes, Basedow's disease, leukemia, pernicious anemia, chorea,

disease of the kidneys, or any constitutional disease, becomes pregnant, she must accept the dangers consequent upon her pregnancy.

If she has no constitutional disease whatever, but is perfectly healthy, and becomes pregnant, and in consequence of the pregnancy itself her life is endangered, she is obliged to accept this danger, even though its results should be fatal.

In neither case does the danger to the mother, no matter how great, give her the right to take the life of her unborn child in order to save her own. As has been said, neither the State, nor the mother, nor the physician, has any dominion over the life of the unborn child; therefore, directly to destroy the life of the unborn child, even as a means to save the life of the mother, is murder—which is forbidden both by the natural law and by divine precept.

De Lee, from whom was quoted the extract above on "Therapeutic Abortion," in writing of "Criminal Abortion," speaks as follows: "One of the saddest commentaries on our modern 'civilization,' in a so-called religious and ethical era, is the prevalence of criminal abortion. A young physician is not long in practice before he is approached, in a hundred ways, open or concealed, to perform a criminal abortion. Not alone the single woman, but the married, will come. All arguments will be brought to bear—that of friendship for a stricken family, the disgrace of a child under untoward circumstances, the impossibility

of caring for a large number of children, ill health, even gold will be offered. The physician should allow none of these things to influence him to do an abortion, because, first, it is murder, and conscience will make his later days miserable; second, it is a criminal offence, etc." (De Lee, p. 1017 and 1018.)

It will be noted that De Lee expressly calls criminal abortion, murder. Why is it murder? It is murder because it is the direct killing of an innocent human being. But in all cases given by De Lee as justifying therapeutic abortion, the unborn child that is killed by therapeutic abortion is not less innocent than the unborn child that is killed by criminal abortion. To kill a child by therapeutic abortion is to destroy the life of an innocent human being, and this is murder. There is therefore no specific difference between therapeutic abortion and criminal abortion;—both are murder and nothing less.

(See p. 28 to p. 60)

Removal of Inviable Fetus

Question 8: If it is morally certain that a pregnant mother and her unborn child will both die, if the pregnancy is allowed to take its course, but, at the same time, the attending physician is morally certain that he can save the mother's life by removing the inviable fetus, is it lawful for him to do so?

Answer: No, it is not. Such a removal of the fetus would be direct abortion.

(See p. 28 to p. 60)

Curettage of Pregnant Uterus in Cases of Threatened or Inevitable Abortion

Question 9: In cases of either threatened or inevitable abortion, is curettage of the pregnant uterus lawful before the fetus is viable, when such a procedure is deemed necessary to save the life of the mother?

Answer: No, it is not lawful, because such a procedure is direct abortion.

Though abortion is threatened, or even inevitable, to have recourse to curettage, as a means of emptying the pregnant uterus, changes a threatened or inevitable abortion into a direct, actual abortion, which is never morally lawful.

Obstetrical writers as a rule recommend some form of curettage, as a means of emptying the pregnant uterus, in certain cases of threatened or inevitable abortion, but such a practice is intrinsically immoral.

Edgar, in treating this point, writes as follows: "The indications for treatment, in all cases of inevitable abortion are the same: namely, first, to control the hemorrhage; and, second, to secure complete evacuation of the uterine contents. Both are best fulfilled by instrumental curettage of the uterus." (Edgar, pp. 341, 342.)

It is never morally lawful to do anything with the direct end in view of emptying the pregnant uterus, when a living inviable fetus is involved.

In cases of incomplete abortion, where the ovum has been expelled, curettage is lawful, because it does not involve the removal of a living, inviable fetus from the uterus.

(See p. 28 to p. 60)

Curettage of Pregnant Uterus Before the Fetus is Viable

Question 10: Are there any conditions that can morally justify the curettement of the pregnant uterus, when the fetus is living and not yet viable?

Answer: No, there are no such conditions. Curettage of the pregnant uterus, when the fetus is living, but not yet viable, is equivalent to inducing direct abortion and is therefore morally unjustifiable. To attribute a hemorrhage, developing before viability, to endormetritis, does not, nor does any other condition, justify curettage of the pregnant uterus before the fetus is viable.

While Question 10, with its answer, covers in a general way the case presented in Question 9, nevertheless, it has been added for the sake of emphasis and clearness.

(See p. 28 to p. 60)

Incarceration of Pregnant Uterus

Question 11: When the pregnant uterus becomes

immovably locked in the upper strait, the fetus being not yet viable, and the attending physician, after trying other expedients, is convinced that the only means by which the uterus may be turned and replaced is to pierce the amnion, and thereby empty the pregnant uterus, is it lawful for him to do so in order to save the life of the mother?

Answer: No, it is not lawful. Such an emptying of the uterus is direct abortion.

Dr. Capellmann, in his work on "Pastoral Medicine," holds that such medical interference, as is outlined in the foregoing question, is indirect abortion, and therefore lawful. In this opinion Dr. Capellmann has been followed by several other Catholic authors.

In defense of his opinion upon this point Dr. Capellmann argues: "The danger to the mother does not lie in the pregnancy, physiologically speaking, but is caused, rather, mechanically, by the enlargement of the womb. The discharge of the waters removes the mechanical obstruction, allows the womb to shrink, and in consequence of the shrinking, makes reposition possible; and the peril of the mother is removed before the abortion, which is certain to follow, may ensue, so that an actual abortion, i. e., the expulsion of the fetus from the womb, will not be necessary for the removing of the danger."

To which argument, Father Klarmann in his work, "The Crux of Pastoral Medicine," replies as follows: "The mother's life is endangered by an accidental

disorder, the locking of the womb, not by the pregnancy as such. If, therefore, the disorder cannot be remedied except by attacking the pregnant womb, abortion is made the cause of the relief to be brought about. The act of piercing the amnion is a direct attack upon the pregnancy, and, therefore, the abortion that follows, is direct abortion."

In discussing this case, Father Klarmann quotes Dr. Stoehr as follows:

"Capellmann argues from the fact that relief of the mother appears immediately after the discharge of the amniotic waters, instead of following after the accomplishing of the abortion. I do not doubt at all, that the discharge of the amniotic fluid brings almost instant relief; but I must deem illusory the distinction between physiological and mechanical pressure, because the mechanical pressure caused by the waters is an absolute consequence of the physiological process of pregnancy, and can in no wise be separated from it.

"Under these circumstances I would unhesitatingly propose laparotomy, and probably save both mother and child.

"This operation has sometimes been performed also in case of the locking of the vacant uterus, with good results (Sanger, Olshausen); and if abortion follows occasionally, it is certainly indirect."

For a full discussion of this case, and a satisfactory

refutation of Dr. Capellmann's opinion, see "The Crux of Pastoral Medicine," p. 73.

(See p. 28 to p. 60)

Pernicious Vomiting
(*Hyperemesis Gravidarum*)

Question 12: In a case of pernicious vomiting which endangers the mother's life, is it ever lawful, as a means of saving the mother's life, to empty the uterus before the fetus is viable?

Answer: No, it is never lawful, for such a proceeding would be direct abortion.

Upon this point Father Klarmann, in "The Crux of Pastoral Medicine," p. 135, quotes Stoehr-Kannamueller as follows:

"Direct abortion—every interference which must necessarily cause the expulsion of the unviable fruit—is permissible under no circumstances, no matter how ethical the object may be. The medico-scientific postulate of abortion is to be judged from the mother's sphere of interest. Here then they insist upon the uncontrollable vomiting of the pregnant, which in many instances appears as early as the first week and often becomes most obstinate. But it generally disappears at the end of the first half of the pregnancy without medical assistance, and, curiously enough, without the nutrition having suffered to a dangerous degree; in particular cases, however, the patient is doomed to a fatal emaciation. In this condition of things, where

the pregnancy is the sole cause of the dangerous vomiting, it was thought proper until recently, to remove at once cause and effect by inducing abortion. But this indication—aside from moral considerations—does not give the right to eliminate the pregnancy; because recent experience teaches that this proceeding brings about the desired result in only one half of the cases, and at present we have other and efficient means at hand, which almost universally produce the desired effect."

On which Father Klarmann comments as follows: "Dr. Stoehr, therefore, contends that a physician that is well informed of the present standing of the obstetrical art, need not resort to abortion in such 'desperate cases,' and 'almost universally' the 'desperate case' is made desperate through the lack of information, or the indifference to morality of the physician.

"But Dr. Stoehr also virtually admits that, in some cases, no remedy will avail.

"Now, the numerical relation of this desperate case to the normal and safe pregnancies does not alter either its moral aspect, or its desperateness.

"What is to be done when the one desperate case of a thousand is brought to the notice of the physician? He applies every conceivable remedy, consults with his experienced confrères, and finds himself unable to relieve the desperateness of the conditions.

"He must leave his patient in the hands of God, who has often righted things that sat awry with greater

hopelessness than these cases. And if the patient dies, let him console himself with the consideration that his conscience is free from the guilt of murder, and that people die of other ailments equally elusive of medical skill and cure."

It might be well to add here that writers on obstetrics distinguish three types of this disease; namely, reflex, neurotic and toxemic.

Dr. Williams, Professor of Obstetrics, Johns Hopkins University, in treating of the disease, writes as follows:

"From what has been said it is apparent that a correct diagnosis is a matter of supreme importance, as the neurotic and reflex types can be readily cured. . . .

"In the reflex variety, the displaced uterus should be replaced and held in position by a properly fitting pessary, or the ovarian tumor should be removed, as the case may be. In the neurotic variety, the patient should be put to bed and kept from her family as far as possible. She should be assured by the physician that her condition is not serious, and will not require active interference. At the same time she should receive large amounts of saline solution by the rectum, and for a day or so no attempt should be made to administer nourishment by mouth. After a few days' rest, however, small quantities of fluid nourishment should be administered at frequent intervals, and the patient assured that her condition will pass off within a short time. Ordinarily, if the physician is sure of

himself and possesses the absolute confidence of the patient, this result will usually follow; but in exceptional instances more radical treatment is necessary, and an absolute rest cure should be insisted upon. In such cases the patient should be isolated from her family and placed in a well-conducted hospital in the hands of a competent nurse. Under such conditions, the régime just indicated will bring about the entire disappearance of the symptoms within a few days." (Williams, pp. 511 and 514.)

In the toxemic variety of the disease, however, Dr. Williams advocates the prompt induction of abortion, "in the hope," as he states, "of arresting the process before the organic lesions have become so pronounced as to be incompatible with recovery." But, as has been stated above, such induction of abortion is intrinsically immoral and therefore unlawful.

(See p. 28 to p. 60)

Eclampsia

Question 13: In a case of eclampsia, which endangers the mother's life, is it ever lawful, as a means of saving the mother's life, to empty the uterus before the fetus is viable?

Answer: No, it is never lawful, for such a procedure would be direct abortion.

Eclampsia is defined by Dr. Williams in his work on obstetrics as follows: "Eclampsia is an acute

toxemia occurring in the pregnant, parturient, and puerperal woman, and is usually characterized by clonic and tonic convulsions, during which there is loss of consciousness followed by more or less prolonged coma. This definition is not, however, strictly correct, for the reason that a number of well-authenticated cases of eclampsia without convulsions have been recorded, and also that other toxemic conditions occasionally occur in obstetrical practice which are likewise accompanied by convulsions or coma." (P. 524.)

With reference to the cause of the disease, Dr. Williams writes as follows: "So many hypotheses have been advanced concerning the etiology of eclampsia, that Zweifel has aptly designated it as 'the disease of theories.' Unfortunately, exact knowledge is still lacking. (P. 535.)

"The present status of the question may therefore be summarized as follows: The clinical history and anatomical findings afford presumptive evidence that the disease is due to the circulation of some poisonous substance in the blood, which gives rise to thrombosis in many of the smaller vessels, with consequent degenerative and necrotic changes in the various organs. But, at the same time, we are absolutely ignorant concerning the nature of the offending substance, and besides, the experimental evidence thus far adduced in favor of such an etiological factor is not convincing." (P. 538.)

As a rule, medical works in treating of this disease

recommend the emptying of the uterus, as a means of checking the convulsions and thereby saving the mother. But this means is far from certain in its results. Writing upon this subject in "The Ethics of Medical Homicide," Dr. O'Malley has the following:

"Lichtenstein reported, from Zweifel's clinic in Leipsic, the result of 400 cases of eclampsia, and he found that the eclamptic convulsions cease in only one-third of the cases after any form of delivery. He says the mortality of induced labor is no better than that after forced delivery, and that the mortality of both methods does not materially differ from the mortality of a long series of cases where there was no such intervention.

"Lichtenstein describes the expectant treatment by phlebotomy and narcotics to replace operative interference, and this method has revolutionized the mortality of the treatment of eclampsia. In ninety-four cases of eclampsia, his mortality was only 5.3 per cent., and none of the deaths could be ascribed to the treatment. The infant mortality was 37.3 per cent., as against 38.8 per cent. in active operative interference during preceding years. Werner, in the Second Gynecological clinic in the University of Vienna, by this new method, in thirty-eight cases of eclampsia had a maternal mortality of 5.2, as Lichtenstein had, but his infant mortality was only 14.65 per cent., an enormous advance for the better. Formerly the mortality

in the Viennese clinic was 15.8 for the women and 44.3 for the children, in a series of 120 cases of eclampsia. A mortality of 50 per cent., in the children, is common in the old method. In Lichtenstein's cases there were mental disturbances in 2.1 per cent. of the women, as against 6.75 per cent. in the old method. Eclamptics may go insane and kill the child after delivery. Lichtenstein treated 74 consecutive cases without a single death. In 54 per cent. of his cases, the convulsions ceased after one venesection, and 42 per cent. of the women with antepartum attacks recovered before labor came on. Engelmann reported a case where a woman who had 188 convulsions recovered after the third venesection." ("Ethics of Medical Homicide," pp. 166, 167, 168.)

This disease ordinarily occurs in the last three months of pregnancy, but at times it has occurred as early as the third month.

When the disease occurs before the fetus is viable, some doctors seek to justify the emptying of the uterus on the ground that the convulsions always kill the fetus. It is not true, however, that the convulsions always kill the fetus. De Lee in the "Principles and Practice of Obstetrics" mentions a case of his own, in which "the patient had two attacks during pregnancy, with an interval of three weeks, in one of which attacks the convulsions were so severe that the jaw was dislocated, and yet a living child was born at term." (P. 355.)

Edgar in "The Practice of Obstetrics" states, "the child may survive several attacks." (P. 290.)

Furthermore, the fact that general statistics show that approximately not more than 42 per cent. of the children die, is fair proof that the convulsions do not always kill the child.

It might be well to add, in this connection, that De Lee notes, that when the attacks kill the fetus, "the symptoms abate, and the product of conception is expelled in due course of time." (De Lee, p. 355.) And Edgar says: "It has been demonstrated by Schauta many times that all derangements, even those of renal origin, subside after the child's death; thus the prognosis will improve, in repeated attacks, in proportion to the early occurrence of its death." (Edgar, p. 291.)

(See p. 28 to 60)

HYDRAMNIOS

Question 14: In an acute case of hydramnios, in which the mother's life is endangered to a degree where expectant treatment could not save her, is it ever lawful to rupture the membranes before the child is viable, and thereby induce abortion in order to save the mother's life?

Answer: No, it is never lawful to rupture the membranes under such conditions, because to do so would be to procure direct abortion.

Hydramnios, or hydramnion, is dropsy of the amnion, or excess of the amniotic fluid.

(See p. 28 to p. 60)

Premature Rupture of Membranes

Question 15: If the membranes rupture before the fetus is viable, is it lawful to bring on abortion, either by the administering of drugs, or by any other means?

Answer: No, it is not lawful under the circumstances to procure abortion, either by the administering of drugs, or by any other means, because to do so would be to procure direct abortion.

It is exceedingly rare for the membranes to rupture before the fetus is viable, but if such an accident should occur, it cannot morally justify the procuring of direct abortion.

Regarding the premature rupture of the membranes, Williams, writing upon the subject, makes the following statement: "Meyer-Ruegg in 1904 collected from the literature 15 cases in which several months elapsed between this occurrence and the completion of labor, though so long an interval is very unusual." (Williams, p. 226.)

(See p. 28 to p. 60)

Hemorrhage

Placenta Praevia

Question 16: In a case where hemorrhage occurs

from *placenta praevia* and endangers the mother's life, before the fetus is viable, is it ever lawful to empty the uterus, as a means of checking the hemorrhage and thereby saving the mother?

Answer: No, it is never lawful to empty the uterus in such a case, because to do so would be to procure direct abortion.

Hemorrhages which endanger the mother's life during pregnancy are attributable most frequently to two causes, namely: *Placenta Praevia* and *Abruptio Placentae.*

Edgar gives the following definition of *placenta praevia*: "The *placenta* is said to be *praevia,* when it is attached to any portion of the lower uterine segment, and since dilation of the segment is necessarily followed by hemorrhage from the separation of the *placenta,* the condition is sometimes called unavoidable hemorrhage." (Edgar, p. 200.)

Edgar gives the following explanation of the cause of the hemorrhage: "The normal arrest of the ovum is a little below the uterine opening of the tubes and above Bandl's ring. This statement is upheld by the fact that the *placenta* is nearly always attached to the side of the uterus. The fundal implantation is very rare. The area of attachment is very small in early pregnancy, and the development of the *placenta* will conform to the growth of that part of the uterus to which it has attached itself. Above, the wall of the uterus becomes thicker and ready for its function

—contraction; below, it becomes thinner and expands. In case the *placenta* is low down it will for a time conform to the uterine changes. First it will enlarge at the point of attachment, then it will expand to a certain degree; but when the limit is reached, then hemorrhage will occur. If the attachment is very extensive or particularly firm, there will occur partial rupture of the placental substance, or the *placenta* will separate from its base. During labor, as dilation continues, the breach between the uterine wall and the *placenta* becomes gradually greater and greater, with each contraction of the uterus new placental tissue is lacerated. The retraction of the uterus from the *placenta* is most clearly seen in those cases in which only a small edge of the *placenta* can be felt when the cervix begins to dilate, but in which nearly the whole *placenta* is lowered when dilation is completed. But this changed position is not so much affected by the descent of the *placenta* as by the ascent of the lower part of the uterus." (Edgar p. 201.)

From this explanation it is easy to see why hemorrhage due to *placenta praevia* seldom occurs before the last three months of pregnancy. However, cases have been known to occur as early as the third month of pregnancy.

"The most characteristic symptom of *placenta praevia* is hemorrhage, which usually does not appear until after the seventh month of pregnancy. At the same time, it is probable that not a few cases of abor-

tion are due to this condition, although the true state of affairs usually escapes observation. I have seen several abortions in the third month which were clearly due to this abnormality." (Williams, p. 813.)

Regarding the treatment of *placenta praevia*, Edgar writes as follows: "There is no preventive treatment of this condition. When the diagnosis of *placenta praevia* is assured, the broad rule is to empty the uterus at once. This is at least the theoretical aspect of the question. In practice, however, numerous conditions assert themselves which constitute exceptions. A certain number, probably constantly decreasing, of practitioners regard intervention before the seventh month as meddlesome. Statistics show that fatal hemorrhage before this period is rare. . . . The minority, who dissent from the routine practice of emptying the uterus at all times, hold that the interruption of pregnancy before viability is unnecessary, unless for special indication, such as profuse hemorrhage. They claim also that if the mother is in no danger, the fetus should be given a chance of survival. The majority, on the other hand, maintain that the mother is always liable to a fatal hemorrhage; that moderate loss of blood up to the time of viability produces a weakening effect on the mother; and, finally, that the chances of the fetus for survival are so slight that they should be disregarded. To the dissent of a portion of the profession must be added the scruples of the prospective mother and her rela-

tives. The idea of terminating the pregnancy without regard to the right of the fetus may be repugnant, and an heir may be greatly desired for more reasons than one." (Edgar, pp. 205 and 206.)

The above extract is given at length, because it practically embodies the teaching found in nearly all standard works on obstetrics. Attention must be here called to two statements in the above quotation, namely: "the chances of the fetus for survival are so slight that they should be disregarded" and "the idea of terminating the pregnancy without regard to the right of the fetus may be repugnant."

The second of these statements is an admission, even from the author, that the fetus has some "right." In treating of the principles governing the morality of abortion, it has been shown that the essential rights of the fetus are inherent in the fetus, and in no sense are these essential rights of the fetus derived from the mother or dependent on her will. These essential rights flow from the law of nature established by the Creator, and therefore these rights are sacred and inviolable, and may not be wilfully violated without incurring the taint of moral guilt. One of the essential and most sacred rights of the fetus is the right to its life. No danger to the mother, however great, can ever be a justification for invading the right to life of the fetus. It is therefore not only "repugnant" to invade the right of the fetus, but it is intrinsically immoral to do so. To attempt to justify

the invasion upon the principle that "the chances of the fetus for survival are so slight that they should be disregarded," is wholly immoral. Such a principle has its origin in sentiment, and rests solely on expediency. It is subversive of the natural law and therefore is intrinsically immoral.

Fortunately, as has been said, hemorrhage from *placenta praevia* seldom occurs before the term of viability, but in cases where it does occur before the fetus is viable, it is not morally permissible to empty the uterus, even to save the life of the mother.

(See p. 28 to p. 60)

SECTION II

Operations Directly Destructive of the Life of the Child

In this section is treated the general question involving operations that are directly destructive of the life of the child. Embryotomy is frequently used to cover all operations that are destructive of the fetus. At other times it is used in a restricted sense. For this reason, Question 17 has been framed in terms to cover all operations that are directly destructive of the life of the fetus.

Direct Killing of the Fetus, Embryotomy, Craniotomy, etc.

Question 17: Is it ever lawful to perform embryotomy, craniotomy, or any other operation, directly destructive of the life of the fetus, whether the fetus is viable or inviable?

Answer: No, it is never lawful. For the proper understanding of question 17, it is necessary to have a clear understanding of what is meant by the words, "directly destructive of the life of the fetus."

An operation is said to be "directly destructive of the life of the fetus," when the operation "directly" kills the fetus.

The killing of a person may be "direct" in either of two ways.

First, when the killing is the immediate end sought in the act of killing.

Second, when the killing is made the means to an end.

Every act by which an innocent human being is "directly" killed is an act of murder, and, consequently, forbidden both by the natural law and by divine precept.

In Section I, Part II, under the answer to question 6, it has been shown that the living fetus is an innocent human being, and, consequently, has all the natural rights of a human being. Of these rights the most sacred and inviolable is the natural right to life.

(See p. 28 to p. 60.)

Furthermore, the living fetus is never an unjust aggressor upon the mother's life; its right to life is not secondary to the mother's right to life, but is equal to the mother's right to life and just as inviolable; and, consequently, any act directly attacking the life of the fetus is wholly unjustifiable on the principles of sound morality.

From what has been said above, all operations "directly" kill the fetus, that make the killing of the fetus a means of saving the mother's life. All such operations are intrinsically immoral, and are identical with wilful murder, and therefore forbidden both by the natural law and by divine precept.

The moral principles stated and explained under the answer to Question 6, apply with equal force to the answer to Question 17. Hence Question 6, together with its answer, and all explanatory matter under it, should be read in connection with the answer to Question 17.

Mutilating Operations Which are Forbidden to be Performed upon a Living Child

The principal operations that are directly destructive of the life of the fetus are enumerated and defined by De Lee as follows:

Mutilating Operations

"Under this caption will be considered the operations which reduce the bulk of the child. Lessened in size, it can be easier gotten through the parturient canal. Embryotomy would be a good general term for all the procedures, but it has been given a particular significance.

"Craniotomy is an operation which consists in opening the fetal head, the evacuation of the brain, and extraction by means of a large bone forceps or a sharp hook.

"Cranioclasis is the third step in the operation, and is sometimes applied to the whole operation. The

instrument, which is nothing more nor less than a large, strong, especially constructed bone forceps, is called a cranioclast.

"PERFORATION is the first step in craniotomy, but is sometimes applied to the whole operation.

"CEPHALOTRYPSIS is an operation in which the head is crushed by means of a powerful forceps supplied with a compression screw, no perforation of the head being made. The instrument is called a cephalatryptor.

"DECAPITATION means what it says—section of the neck—and is accomplished either by means of a blunt hook or a sickle-knife, the *ecraseur,* or scissors.

"EMBRYOTOMY is applied to decapitation, to the section of the fetal trunk, or to the opening of the body cavities.

"EXENTERATION means disemboweling the fetus to diminish the size of the trunk. It is the same as EVISCERATION.

"BRACHIOTOMY means section of an arm.

"CLEIDOTOMY consists of section of the clavicles, and is used when the shoulders are too broad to pass, the head being delivered and the child dead."

Note. Cleidotomy is unlawful when applied to a living child.

"SPONDYLOTOMY is section of the spinal column." (De Lee, p. 1005.)

All the above operations, performed upon the living child, are directly destructive of its life, and are there-

fore murder. The condition of the mother, no matter how desperate, can never morally justify any operation that is directly destructive of the life of her unborn child.

The Use of Electricity, X-Rays, and Similar Means to Destroy Fetal Life

All uses of electricity, X-rays, and similar means to destroy directly the life of the fetus, are just as intrinsically immoral as craniotomy upon the living child, and hence they are never morally justifiable.

Common Teaching of Standard Works upon the Subject of Embryotomy

Under the heading of Embryotomy, Edgar comprises all operations upon the fetus which have for their object a sufficient reduction in size to make extraction possible by the natural passages. (Edgar, p. 921.)

He states that embryotomy upon the living fetus is indicated in two instances, namely:

First "in obstructed labor due to monstrosity."

Second "in exceptional cases in which the mother's condition from hemorrhage, repeated attempts at delivery, sepsis or shock, is such as to render embryotomy by far the safer operation." (Edgar, p. 922.)

Let it be noted that in the "exceptional cases" referred to by Edgar, embryotomy, which is a direct killing of the child, is advocated because it is the "safer operation." It is "safer" for the mother, but it is directly destructive of the life of the child. In plain terms, the direct killing of the child is made the means of saving the mother's life.

"Some practitioners," says Edgar (p. 922), "who repudiate the operation of embryotomy, propose that one shall wait for the fetus to die from birth-pressure, in order that the operation can be performed without compunction. This is a hazardous and possibly fatal concession. For therapeutic feticide see page 867."

Referring to page 867, as indicated, the following statements are found:

"Induction of abortion is performed entirely in the interest of the mother; induction of premature labor may be done in the interest of either or both.

"For the conscientious physician, the interruption of pregnancy naturally involves great responsibility, but when it is the only method of saving the life of the mother, or when without it her life is placed in imminent danger, it is usually regarded as not only justifiable but imperative." (Edgar, p. 867.)

Upon what principle of sound morality "it is usually regarded as not only justifiable but imperative" to disregard the natural and inherent right of the fetus to its life, the author does not state.

In treating of Craniotomy, Willams makes the following statements:

"On the other hand, if the child is alive, the operation is justifiable only in exceptional cases; indeed, Pinard and some others hold that, in view of the satisfactory results obtained from pubiotomy and Cæsarean section, it should never be performed. This, however, must be looked upon as too radical a view, and one demanding a certain amount of qualification; for, although it must ever be the duty of the obstetrician to do his best to save the life of both mother and child, it is, nevertheless, readily conceivable that conditions may arise, under which Craniotomy upon the living child may not only be perfectly justifiable, but even imperatively demanded." (Williams, p. 463.)

Here the opinion of Pinard and others that Craniotomy should never be performed upon the living child, is set aside as "too radical," and again the statement is made that, in certain instances, Craniotomy upon the living child, is "not only perfectly justifiable, but even imperatively demanded."

But it is not stated, on what principles of sound morality it is "perfectly justifiable" and "imperatively demanded." Williams continues: "Generally speaking, Craniotomy should not be performed upon the living child, if the mother is in good condition, amid suitable surroundings, and in the hands of a competent operator. Under such circumstances, if the obstacle to labor be due to a contracted pelvis or an excessively large

child, Cæsarean section, or, in certain cases, pubiotomy is preferable, inasmuch as the slight increased risk to the mother is more than compensated for by the rescue of her offspring." (Williams, pp. 463, 464.)

Let it be carefully noted that the sacred and inviolable right of the fetus to its life is to be given consideration only "when the mother is in good condition, amid suitable surroundings and in the hands of a competent operator"—all of which conditions are accidental and wholly external to the fetus. It is needless to state here that it is contrary to all the principles of right reason and sound morality, to make the inherent right of the fetus to its life dependent upon accidental conditions of the mother.

"On the other hand," Williams continues, "if the woman is not seen until she has been in the second stage of labor for a considerable time, and has been subjected to repeated examinations and possibly presents signs of infection, Cæsarean section is not indicated, but the child should be sacrificed in the interests of the mother, inasmuch as the maternal mortality attending Cæsarean section under such circumstances is in the neighborhood of 25 per cent. Again, if the child is not in good condition, as shown by a too rapid or too slow heart-beat, or by the passage of considerable quantities of meconium with a vertex presentation, its life is already in such peril that, against that of the mother, it is no longer entitled to serious consideration." (P. 464.)

Here it is stated that, under certain conditions, "the child should be sacrificed in the interests of the mother," and the only reason assigned for such sacrifice is, that "the maternal mortality attending Caesarean section under such circumstances is in the neighborhood of 25 per cent.—" which simply means, that to prevent the possible raising of the maternal mortality from 5 per cent. to 25 per cent., by recourse to the Cæsarean section under the circumstances noted, it is perfectly justifiable to kill directly 100 per cent. of the children by Craniotomy. On what principle this is justifiable is not stated. According to statistics, the maternal mortality attending "conservative Cæsarean section, when properly performed upon uninfected patients amid good surroundings, is in the neighborhood of 5 per cent." (Williams, p. 450.)

It is further stated that, under the circumstances mentioned, "the life of the child is already in such peril that, against that of the mother, it is no longer entitled to serious consideration."

This statement implies two things: first, the comparison of values of two human lives; second, because the less valuable life is already in peril, it should be sacrificed in the interest of the more valuable life.

In treating of the principles that make direct abortion intrinsically immoral, under Question 6, it has been shown that, in the possession of the essential rights of human nature, there is no such thing as priority or superiority. The most worthless human

life is just as sacred and inviolable as the most valuable human life, as long as its possessor is guiltless of unjust aggression.

The statement of Williams above implies the setting up of the principle: "When a person has no chance to live, another may freely dispose of his right to live, for certain accidental reasons." If this principle were admitted, the following conclusions, which flow logically from it, must be admitted:

In a case where the plague should break out on board a ship at sea, persons afflicted with the plague and inevitably doomed to death, might be justifiably thrown overboard, to save the more valuable lives of those not yet infected.

In cases of persons suffering untold agony, and inevitably doomed to death within a short time from a virulent form of cancer, or other disease, doctors would be justified in giving the sufferers a deadly dose of morphine, to deliver them from their sufferings.

These, and many similar conclusions, logically follow from the principles implied in the proposition advanced by Williams to justify Craniotomy upon the living child.

The desperateness of Craniotomy upon the living child is frankly revealed by De Lee in the following passage: "When the child is living, the indication for Craniotomy is dreadfully hard to place. Nowhere in all medicine does so heavy a responsibility rest on the medical attendant. He is judge, jury, and perhaps

executioner of an innocent baby, and he can hardly be blamed if he shrinks from the painful task. However, if he has not the moral courage to do what his judgment tells him is the best for the mother, her family, and the State, he should give way to a better man." (De Lee, p. 1006.)

This whole passage is pervaded by a sense of insecurity, and involves a strange misuse of the terms, "moral courage," "what is best," and "better man." It requires no "moral courage" to kill an innocent baby, but it does require a total disregard for the sacred rights of human life.

To imply that Craniotomy, under certain conditions, is "what is best for the mother, her family, and the State," is wholly unjustifiable upon the principles of sound philosophy and sound morality. The State exists for the individual, and not the individual for the State. One of the primary purposes of the State is to protect the individual in his natural rights, the most sacred of which is the right to life. The State has not absolute dominion over the life of the individual. For the State to invade the right of the individual to his life, as long as the individual is innocent, is an act of the highest injustice, and in its last analysis, it is subversive of the basic principles upon which the State is founded. Craniotomy upon the living child, no matter for what reason it may be performed, is an invasion of the right to life of an innocent human being, is morally unjustifiable, and,

therefore, can never be truly said to be "what is best for the mother, her family and the State."

Further, De Lee states: "Pinard and a few Catholic authors demand the abolition of Craniotomy on the living child, but the overwhelming majority of obstetric authorities declares this extreme position untenable."

It may be well to note that these authorities "declare" Pinard's position to be "untenable," but these same authorities find it utterly impossible to prove his position untenable, by an appeal to the principles of sound morality.

De Lee continues: "All, however, agree that the necessity for destroying the child is less and less frequent as the diagnosis of spacial disproportion is earlier discovered, giving a chance for cesarean section and pubiotomy. It follows, therefore, that Craniotomy will be more frequently performed in home practice.

"In a good maternity, the necessity for sacrificing the baby will be of the rarest occurrence. For centuries, Craniotomy was the opprobrium of obstetric art. It is this no longer in the art, but remains such in obstetric practice." (De Lee, p. 1007.)

From these passages it is evident that the right of the fetus to its life in certain cases, rises or falls "as the diagnosis of spacial disproportion is earlier discovered."

De Lee concludes: "Legally, the mother has a right to demand that she be exposed to no unusual danger

for the sake of her child, and she may refuse to do so even at the request of her husband. Also, she has the right, even if opposed by her husband, to run added risk for its sake if she wishes. The legal status of the unborn child is still unsettled (Kiernan). At present it is part of its mother, and has no legal existence until the cord is cut. The mother may recover damages for its loss by willful or negligent means, though itself it has no redress if it survives the injury. The moral and ethical aspects of the question are too broad to be more than mentioned here. The stand of the Catholic Church has been alluded to—'Non Occides'!—And in such families the attendant is guided by the word of the priest who is always to be summoned. If the accoucheur is convinced that the cesarean section demanded would kill the mother, he may retire from the case. On the other hand, if the family insists on the sacrifice of the child, when the accoucheur feels that there are good chances for a successful cesarean section, he should likewise decline, but, legally, he must stay by the patient until another qualified practitioner has assumed charge." (De Lee, p. 1007.)

With reference to this passage it may be well to note that the terms "Legal" and "Moral" are far from being identical. In all ages of civilization there have been enacted laws that have been contrary to the principles of sound morality. Therefore what is "Legal" is not necessarily "Moral." If the "un-

usual danger" to which the mother is exposed arises from the pregnancy, she has a moral obligation to endure the "unusual danger," no matter what her so-called "legal right" may be under the circumstances. Any human law that attempts to confer upon a pregnant mother the "legal right" to terminate her pregnancy by the direct destruction of her child, because of "unusual danger" to her life, arising out of the pregnancy, is a law that is contrary to the principles of morality, because it is in contravention of the natural law.

Upon the sentence: "At present it is part of its mother, and has no legal existence until the cord is cut," it may be observed that, while the unborn child may have no legal existence, it is neither physically nor entitatively, part of its mother. As was stated in the preceding section, "Medical Jurisprudence" (p. 11), of Wharton and Stillé, quotes Dr. Hodge, of the University of Pennsylvania, as follows: "Imperfect in the first instance, nay, even invisible to the naked eye, the embryo is nevertheless endowed, at once, with the principles of vitality; and although retained in the system of the mother, it has in a strict sense an independent existence."

As in the present instance, so throughout his work, De Lee consistently advises that the religious beliefs of Catholic patients must be taken into consideration, where these are in conflict with obstetrical practice.

With regard to the concluding statements of De

Lee, it must be noted that a priest could neither demand, nor even advise, the performance of a cesarean section in a case where "the accoucheur is convinced that the cesarean section would kill the mother." Such a cesarean section would be murder, and where such a cesarean section is demanded, the accoucheur not only "may retire from the case," but is morally bound to do so, because, as it is not lawful to kill the child in the interest of the mother, neither is it lawful to kill the mother in the interest of the child.

Edgar, Williams, and De Lee have been quoted at length, because, from reading certain books, a person would get the impression that Craniotomy upon the living child has been long since banished from obstetrical practice, and nevertheless, here are three standard authors whose works are in prevalent use throughout the country, all advocating Craniotomy upon the living child under certain conditions. The principles underlying the teaching of these authors upon the point in question are not the principles of sound morality, but principles of so-called "necessity," and the evaluation of the life of the mother as superior to that of the child. These principles, in their application to Craniotomy, are wholly immoral, and, in their last analysis, are reducible to the single principle of "expediency."

This chapter may be brought to an appropriate conclusion with an extract from "Moral Principles and Medical Practice" (pp. 55, 56, 57), which runs as follows: "My second extract is from an article of

Dr. M. O'Hara, and is supported by the very highest authorities: "Recently (August 1, 1893) the British Medical Association, the most authoritative medical body in Great Britain, at its sixty-first annual meeting, held at Newcastle-upon-Tyne, definitely discussed the subject before us. In the address at the opening of the section of Obstetric Medicine and Gynecology, an assertion was put forth which I regard as very remarkable, my recollection not taking in any similar pronouncement made in any like representative medical body. The authoritative value of this statement, accepted as undisputed by the members of the association, which counts about fifteen thousand practitioners, need not be emphasized.

"Dr. James Murphy (British Medical Journal, August 26, 1893) of the University of Durham, made the presidential address. He first alluded to the perfection which the forceps had reached for pelves narrowed at the brim, and the means of correcting faulty position of the fetus during labor. He then stated: 'In cases of great deformity of the pelvis, it has long been the ambition of the obstetrician, where it has been impossible to deliver a living child through the natural passages, to find some means by which that child could be born alive with comparative safety to the mother; and that time has now arrived. It is not for me to decide,' he says, 'whether the modern cesarean section, Porro's operation, symphyseotomy, ischiopubotomy, or other operation is the safest or

most suitable, nor yet is there sufficient material for this question to be decided; but when such splendid and successful results have been achieved by Porro, Leopold, Saenger, and by our own Murdoch Cameron, I say it deliberately and with whatever authority I possess, and I urge it with all the force I can master, that we are not now justified in destroying a living child, and while there may be some things I look back upon with pleasure in my professional career, that which gives me the greatest satisfaction is that I have never done a Craniotomy on a living child.' "

Upon this passage Father Coppens remarks: "You will please notice, gentlemen, that when this distinguished Doctor said, 'We are not now justified in destroying a living child,' he was speaking from a medical standpoint, and meant to say that such destruction is now scientifically unjustifiable, is a blunder in surgery. From a moral point of view it is not only now, but it was always, unjustifiable to slay a child as a means to save the mother's life; a good end cannot justify an evil means, is a truth that cannot be too emphatically inculcated."

SECTION III

Indirect Abortion and Indirect Killing

In this section are treated questions involving either "Indirect Abortion," or "Indirect Killing," of the fetus, together with a few questions concerning medical treatment that involves a danger to the fetus. Since the general moral principle which governs questions contained in this section, is somewhat more complex, in itself and in its application, than the principles governing the questions of the two preceding sections, brevity of statement has been sacrificed for the sake of clearness. This will account for what may appear to be needless repetitions of the statement of principles.

Indirect Abortion

Question 18: What is indirect abortion?

Answer: Indirect abortion is abortion that results from the employment of means that are used for some other end than the expulsion of the fetus, although it is foreseen that they may unintentionally cause the expulsion of the fetus.

Abortion, therefore, is indirect, when it is not made the end either of the operator or of the operation, or when it is not made a means of achieving even the

ultimate end of the operator or of the operation.

Indirect Killing

Question 19: When is killing indirect?

Answer: Killing is indirect, when it is neither intended as an end for its own sake, nor chosen as a means toward an end, but is attached as a circumstance to the end or the means. ("The Ethics of Medical Homicide," p. 15.)

The general question that presents itself, in this section, for solution is this:

Is it ever lawful, under any circumstances, to administer a treatment to a pregnant woman, or to perform an operation upon her, that might cause an abortion, or might result in a killing of the fetus?

The answer to this question is: Yes, it is lawful, when certain conditions are verified, which conditions make either the abortion indirect, or the killing indirect.

Since this affirmative answer depends upon the fulfilment of certain conditions, it is of the highest importance to have a clear understanding of what these conditions are.

These conditions are fully determined by the well-established principle of ethics that determines the legitimacy of voluntarily placing a cause that produces two effects, one good, and the other evil.

This principle may be briefly stated as follows: It is lawful to place a cause from which two effects

will flow, one good, the other evil, provided the four following conditions are fulfilled:

First, that the cause is good in itself, or at least morally indifferent.

Second, that the good effect follows as immediately and directly from the cause as the evil effect.

Third, that there is a proportionately grave reason for placing the cause.

Fourth, that the evil effect is not intended, either immediately or remotely.

These four conditions must be fully verified before it is lawful to place a cause having two effects, the one good, the other evil.

First Condition

The reason for the first condition, that the cause in itself must be good, or at least morally indifferent, is this: if the cause itself were evil, there would be a moral obligation to refrain from placing such a cause. No matter how good the ultimate end intended might appear to be, it can never morally justify the placing of a cause that is evil in itself.

Second Condition

The reason for the second condition, that the good effect must follow as immediately and directly from the cause as the evil effect, is this: if the good effect

were not to follow as immediately and directly from the cause as the evil effect, it would necessarily be subordinated to the evil effect, and would be obtained only by means of the evil effect. This would be doing evil that good might come of it, which is a direct violation of the fundamental principle of morality, that "it is never lawful to do evil that good may come of it."

It is the violation of this second condition that makes of every therapeutic abortion, a criminal abortion. Every treatment administered by a physician to produce therapeutic abortion has two effects: one good, the cure of the mother; the other evil, the expulsion of the inviable fetus. But the good effect, the cure of the mother, is subordinated to the evil effect, the expulsion of the inviable fetus, and is obtained only by means of the evil effect. In other words, the good effect does not follow as immediately and directly from the cause as the evil effect.

Third Condition

The reason for the third condition, that there must be a proportionately grave reason for placing the cause, is this: it would not be equitable to permit a grave evil in order to accomplish a slight good. In other words, in placing a cause that has two effects, one good and the other evil, there must be a just proportion between the good effect intended, and the

evil effect permitted. Taken in conjunction with indirect abortion and indirect killing, this condition is fulfilled only when the mother's life is endangered. This condition is violated, when a drug or treatment that is likely to cause abortion, is administered to relieve an illness that does not actually endanger the life of the pregnant woman. There is not a just proportion between the probable abortion and the cure of an illness that does not endanger the woman's life.

Fourth Condition

The reason for the fourth condition, that the evil effect must not be intended either immediately or remotely, is this: to perform a good act with even the remote intention of producing an evil effect is morally wrong. An evil intention vitiates even a good act. Hence in placing a good cause that has two effects, the evil effect must neither be intended nor approved, but merely permitted to happen.

For the sake of clearness, the general question will be restated here, and the above principles applied to it.

Medical Treatment, or Surgical Operation, That Might Result in Indirect Abortion, or Indirect Killing of the Fetus

Question 20: Is it ever lawful, under any circumstances, to administer a treatment to a pregnant

woman, or perform an operation upon her, that might cause an abortion, or might result in a killing of the fetus?

Answer: Yes, it is lawful under the four following conditions:

First Condition

That the act involved in administering the treatment, or in performing the operation, is morally good, or at least indifferent in itself. This condition is violated by every act that tends to produce direct abortion, or to result in a direct killing of the fetus (see Question 17), because every such act is intrinsically immoral in itself, and no ultimate purpose, however good it may appear to be, can ever morally justify the placing of such an act. Consequently, every form of direct, medical or therapeutic abortion, and every form of embryotomy upon the living child, no matter what the ultimate purpose of the physician may be, involve a violation of this condition, because they involve a direct attack upon the life of an innocent human being, and such an attack is an act that is intrinsically immoral.

This first condition is not violated by the cautious administration of morphine in a case of threatened abortion, nor by surgical operations that do not involve a direct attack upon the fetus.

The cautious use of morphine, in a case of threat-

ened abortion, means that the morphine is used solely to quiet the woman and to check uterine irritability, and thereby avert the threatened abortion. Such an act is morally indifferent in itself, because instead of being a direct attack upon the life of the fetus, it is resorted to as a means of saving the life of the fetus, by averting the threatened abortion.

Second Condition

That the good effect, which is the saving of the life of the mother, follow as immediately and directly from the treatment or operation as the evil effect, which is the abortion, or the killing of the fetus.

This condition is fulfilled, for instance, in an operable case of carcinoma of the uterus, in which the pregnant uterus, with its *adnexa,* is totally removed before the fetus is viable. In such a case, the good effect, the saving of the life of the mother, follows as immediately and directly from the operation as the evil effect, which is the death of the fetus. But the good effect in this case is not subordinated to the evil effect, nor is it obtained by means of the evil effect. The saving of the mother's life does not result from the death of the fetus, but it results directly from the removal of the cancerous uterus.

This second condition is violated by every form of direct medical or therapeutic abortion, and by every

form of embryotomy upon the living child, because in these the good effect, the cure of the mother, is obtained by means of the evil effect, and hence it does not follow as immediately and directly from the cause as the evil effect.

Third Condition

That there be a proportionately grave reason for placing the cause. This condition is fulfilled, when the medical treatment administered, or the operation performed, is actually necessary to save the mother's life, though it indirectly involves a danger to the life of the fetus. Here the good effect intended, the saving of the life of the mother, is justly proportionate to the evil effect permitted, the indirect abortion, or the indirect killing of the fetus.

This condition is violated, when, to relieve an illness that does not actually endanger the mother's life, a treatment is administered, or an operation performed, that is likely to result in the death of the fetus; because there is not a just proportion between the probable death of the fetus and the cure of an illness that does not actually endanger the mother's life.

This condition is violated, when, during pregnancy, to relieve physical pain not endangering the mother's life, morphine is administered in such quantities as to expose the fetus to fatal narcosis.

It would also be violated by such an operation as a total removal of a pregnant uterus before the term of viability, if the case involved nothing more serious than the presence in the pregnant uterus of a small fibroid tumor, which, there is reason to believe, will not endanger the mother's life until after the term of viability has been reached.

Fourth Condition

That the evil effect, the abortion, or the killing of the fetus, be not intended either immediately or remotely. The abortion, or killing of the fetus, must not be intended,—either as an end or a means to an end.

All forms of direct abortion, or of embryotomy upon the living child, involve a violation of this condition.

The foregoing answer, with its four requisite conditions, together with the answers to Questions 22 and 23, should govern the use of radiotherapy during pregnancy. In cases of pregnancy, where the application of radiotherapy actually endangers the life of the fetus, without at the same time averting a corresponding danger from the life of the mother, its use is not morally justifiable. Intensive irradiation, especially in the early stages of pregnancy, constitutes a real danger to the life of the fetus.

(See p. 96 to p. 101)

Removal of Appendix, Gall Bladder, or Some Other Organ, During Pregnancy

Question 21: If, during pregnancy, before the fetus is viable, a pregnant woman's life becomes endangered by a disease of the appendix, or of the gall bladder, or of some other organ, is it lawful to remove such an organ, provided the removal does not involve a direct attack upon the life of the fetus, but may result either in indirect abortion, or in indirectly causing the death of the fetus?

Answer: Yes, it is lawful.

The removal of such an organ is lawful, because the question implies the fulfilment of the four conditions that are requisite to justify the placing of a cause that has two effects, one good, and the other evil.

The first condition is fulfilled, because the act of removing such an organ is an act that is at least morally indifferent in itself.

The second condition is fulfilled, because the good effect, the cure of the woman, follows as immediately from the cause, as the evil effect, the probable indirect abortion, or the indirect killing of the fetus.

The third condition is fulfilled, because the reason for placing the cause is the saving of the life of the mother, and there is a just proportion between this reason and the probable death of the fetus.

The fourth condition is fulfilled, because the question implies that the indirect abortion, or indirect killing of the fetus, is not intended either immediately or

remotely, but is simply tolerated or permitted to happen.

(See p. 96 to p. 101)

A Medical Treatment Likely to Cause Abortion, When A Woman's Life is not in Danger

Question 22: If, during pregnancy, before the fetus is viable, a woman is suffering from an illness that does not endanger her life, is it lawful, in seeking to relieve such an illness, to administer a treatment that will probably cause an abortion, or will probably result indirectly in the death of the fetus?

Answer: No, it is not lawful, because, in accordance with the principles explained on pages 98 to 101, it is not morally justifiable to expose the fetus to probable death, in order to relieve an illness that is not dangerously serious to the woman.

This answer applies to the use of radiotherapy in cases covered by the question.

A Medical Treatment not Likely to Cause Abortion, When A Woman's Life is not in Danger

Question 23: If, during pregnancy, before the fetus is viable, a woman is suffering from an illness that does not endanger her life, is it lawful, in seeking

to relieve such an illness, to administer a treatment that involves only a slight risk of causing an abortion, or of indirectly resulting in the death of the fetus?

Answer: Yes, it is lawful, because the case involved in the question implies the fulfilment of the conditions stated on page 98. There is a just proportion between the good to be obtained and the slight risk that is run.

This answer applies to the use of radiotherapy in cases covered by the question.

(See p. 96 to p. 101)

Threatened Abortion—Use of the Tampon

Question 24: In a case of threatened abortion, in which the hemorrhage does not actually endanger the woman's life, is it lawful to tampon the uterine cervix and the vagina?

Answer: No, it is not lawful. It must be noted that the question treats specifically of "threatened" abortion, and not "inevitable" abortion. The distinction between "threatened" abortion and "inevitable" abortion is described by Edgar as follows: "In threatened abortion the clinical picture shows a hemorrhage bright in color, free from clots, intermittent in character, fairly persistent, and moderate in amount; there is little pain or none at all; the *os* is somewhat dilated, but does not allow the passage of the finger; the uterus

is soft, anteflexed, and intermittent contractions are infrequent. The symptoms may subside, or persist and result in a complete or an incomplete abortion. As long as a chance of the subsidence of the symptoms exists, the abortion is said to be threatened. In inevitable abortion the hemorrhage is persistent, increasing in amount, and consists in clots and fragments of the *ovum* and *liquor amnii;* pain and uterine contractions are present and increase in severity; the *os* is dilated and admits the examining finger, which palpates the *ovum* within the *os*; the uterus is alternately soft and hard, and is tetanically contracted. The *ovum* perishes and is expelled, or occasionally is retained, as in missed abortion." (Edgar, p. 336, 5th Edition.)

Upon the same subject Williams writes as follows: "When the patient in the first weeks of pregnancy begins to lose blood, and the flow is associated with pain in the lower abdomen and back, an abortion is threatened. It, however, does not become imminent, unless the hemorrhage be profuse, or the cervix considerably dilated; even in the latter case, it is not impossible for the disturbance to subside, and for the pregnancy to go on without interruption. On the other hand, rupture of the membranes and escape of the *liquor amnii* indicate that the abortion is inevitable.

"When abortion becomes imminent, the hemorrhage

is usually quite profuse, though as a rule not sufficient to endanger the life of the woman." (Williams, p. 617.)

De Lee has the following: "An abortion may appear threatening for hours, days or even months, and yet pregnancy go on to full term. Again, suddenly, profuse hemorrhage occurs, pains set in, and the process becomes inevitable." (De Lee, p. 423.)

From the foregoing quotations it is evident that in "threatened" abortion, the hemorrhage does not actually endanger the woman's life. Williams even says: "When the abortion becomes imminent, the hemorrhage is usually quite profuse, though as a rule not sufficient to endanger the life of the woman."

To tampon the vagina and the uterine cervix in threatened abortion, results, as a rule, in changing the threatened abortion into a complete abortion within twenty-four hours. And a complete abortion means the certain death of the fetus. Therefore, to use the tampon in cases of threatened abortion, is to place a cause having two effects: the one good, the checking of the hemorrhage; the other evil, the bringing on of complete abortion. As has been seen above, the hemorrhage in question is not one that actually endangers the woman's life; but the complete abortion means the certain death of the fetus. There is not, therefore, a just proportion between the good effect intended, the checking of the hemorrhage, and the evil effect per-

mitted, the death of the fetus, resulting from the abortion, and consequently, to use the tampon under the circumstances is not morally justifiable.

To do so would be a violation of the third condition requisite to justify the placing of a cause having two effects, one good, and the other evil.

(See pages 98 to 101)

Inevitable Abortion—Use of Tampon

Question 25: In a case of inevitable abortion, in which the hemorrhage is so profuse as to endanger the woman's life, is it lawful to tampon the uterine cervix and the vagina, in order to check the hemorrhage?

Answer: Yes, it is lawful.

There are three points in the question that must be carefully noted: first, the abortion is inevitable; second, the hemorrhage is so profuse as to endanger the woman's life; third, the tampon is used for the purpose of checking the hemorrhage.

For the distinction between "threatened" abortion and "inevitable" abortion, see answer to Question 24.

Even in cases of inevitable abortion, in which the hemorrhage is not so profuse as to endanger the woman's life, the use of the tampon is not morally justifiable. To such cases of inevitable abortion the answer to Question 24 must be applied in full.

The fact that the abortion is inevitable does not justify the use of the tampon, but its use is justified

solely by the circumstance that the hemorrhage is so profuse as to endanger the woman's life, and the tampon is the means of last resort to check the hemorrhage.

To use the tampon in the case involved in Question 25 is to place a cause having two effects, one good, and the other evil, in which all the conditions requisite to justify the placing of such a cause are fulfilled.

First, the cause, namely the tamponing of the cervix and the vagina, is an act that is at least morally indifferent, since the question states that the purpose of the act is to check the hemorrhage, and not to induce abortion.

Second, the good effect, the saving of the mother's life by checking the hemorrhage, follows as immediately and directly from the cause as the evil effect permitted, namely, the abortion. Here the good effect is not subordinated to the evil effect. The mother's life is not saved by the abortion, but by the checking of the hemorrhage, and the hemorrhage is checked by the use of the tampon.

Third, the good effect intended, the saving of the mother's life, is justly proportionate to the evil effect permitted, the abortion. Therefore there is a proportionately grave reason for placing the cause.

Fourth, the question expressly states that the tampon is used to check the hemorrhage, and this implies that the permitted abortion is not intended, either immediately or remotely.

Under the conditions expressly stated in the question, it is therefore lawful to use the tampon.

Standard works on obstetrics do not hesitate to recommend the use of the tampon in cases of inevitable abortion, as a means of emptying the uterus. Such a practice is morally unjustifiable, because to place any act for the purpose of emptying the uterus before the fetus is viable, is to be guilty of direct abortion, and direct abortion is intrinsically immoral, and hence always unjustifiable.

(See p. 96 to p. 101)

Use of Morphine in Threatened Abortion

Question 26: In a case of threatened abortion, is the cautious administration of morphine lawful, even though its use involves a real danger to the fetus?

Answer: Yes, it is lawful.

This answer is based upon the fact that in certain cases of threatened abortion, the cautious administration of morphine is the only practical means of quieting the woman and checking uterine irritability, and thereby averting the threatened abortion.

Here are fulfilled the four conditions required for placing an act that has two effects, one good and the other evil.

First, under the circumstances, the cautious administration of morphine is an act morally indifferent.

Second, the good effect, namely, the averting of the

threatened abortion, follows as immediately and directly from the cause as the probable evil effect, namely, the danger to the fetus from fetal narcosis.

Third, the probable averting of the threatened abortion is proportionate to the probable danger to the fetus.

Fourth, the evil effect, namely, the danger to the fetus, is not intended, either immediately or remotely.

The point involved in the question is fully covered by Dr. O'Malley, in treating of Threatened Abortion. He writes as follows:

"In threatened abortion, examination is to be avoided, unless it is absolutely necessary for diagnosis, and then great gentleness is required so as not to excite uterine contractions. The woman is to rest in bed, not so much as raising her head to take a drink of water (which is given her through a tube), and she is morally obliged to submit to this inconvenience. If she refuses, she is accountable for the death of the fetus. If there is bleeding, the foot of the bed should be elevated, as in hemorrhage in typhoid fever. The routine practice is to quiet the woman and the uterine irritability with morphine and other opium derivatives. Children are readily overwhelmed by opium, because their circulation is not sufficient to neutralize the de-oxidizing effects of the drug up to safety. While the embryo is connected with the maternal circulation through the *placenta,* the mother's circulation

often safeguards the fetus from the effects of the opium. The danger to the child, in such cases, begins from the opium remaining in its circulation, after the child has been separated from the mother. Often, however, fetuses, in cases where scopolamine and morphine have been used on the mother during labor, are born, badly, and even fatally, narcotized, despite the connection with the maternal circulation. Nevertheless, even if there is some real danger to the fetus from the use of morphine in a threatened abortion, the cautious use of this drug would be morally justifiable. Should the threatened abortion go on to actual abortion, the fetus will certainly be killed, but use of morphine on the woman is the best and virtually the only means we have, to avert a threatened abortion and so save the fetal life. The immediate double effect, from the morally indifferent act of giving a dose of morphine, is, on the good side, the saving of the fetal life, and on the other, the evil side, the danger of fetal narcosis, which is not at all certain to follow. Evidently, the good, intended effect far outbalances the evil, and somewhat hypothetical, effect." ("The Ethics of Medical Homicide and Mutilation," pp. 101, 102.)

(See p. 96 to p. 101)

Large Doses of Morphine During Pregnancy

Question 27: Is it lawful to administer large doses

of morphine, during pregnancy, for the relief of physical pain that does not involve a real danger to the mother or the fetus?

Answer: No, it is not lawful, because large doses of morphine are dangerous to the fetus, and this danger should not be incurred without a proportionately grave reason. The relief of the physical pain, involved in the question, is not proportionate to the danger incurred by the fetus, and therefore, the administration of large doses of morphine, under the circumstances, would not be morally justifiable. It would be a violation of the "Third condition" stated on page 98 and explained on pages 99 and 100.

Administration of Quinine for Malaria, During Pregnancy

Question 28: Is it lawful to administer quinine, in sufficient quantities to counteract a malarial infection that develops during pregnancy, before the fetus is viable?

Answer: Yes, it is lawful, because, in such cases, there is practically no danger of quinine having an oxytocic effect, and its administration is most beneficial to the mother. Quinine is a specific for malaria, and, when administered during pregnancy to women suffering from malaria, the malarial infection neutralizes the oxytocic properties of the drug.

In treating this point, Williams writes as follows: "Quinine should be administered unhesitatingly to women suffering from malaria during pregnancy, as its oxytocic properties are apparently in abeyance under such conditions, so that it can be used with impunity without fear of setting up uterine contractions." (Williams, "Obstetrics," p. 485.)

(See p. 96 to p. 101)

Administration of Quinine During Pregnancy, in the Absence of Malarial Infection

Question 29: In the absence of malarial infection, is it lawful to administer large doses of quinine, during pregnancy, before the fetus is viable?

Answer: No, it is not lawful. There can be no valid reason for the administration of large doses of quinine in the case involved in the question. In the absence of malarial infection, quinine, administered in large doses to a pregnant woman, before the term of viability, is liable to have an oxytocic effect which may result in abortion. Therefore, its use, under the circumstances, constitutes a real danger to the fetus. This danger to the fetus is not offset by any proportionate benefit to the mother, resulting from the use of the drug. Its administration, therefore, in the case involved in the question, is not morally lawful.

(See p. 96 to p. 101)

Removal of Pregnant Uterus in Case of Myoma

Question 30: If, during pregnancy, tumors form in the muscular tissue of the uterus, and grow to such an extent, before the fetus is viable, as to endanger the life of the mother, is it lawful to excise totally the impregnated uterus, if this is the only means left of saving the mother's life?

Answer: Yes, it is lawful.

In this case, the death of the child is indirect, not direct. The removal of the fetus is not made, in any sense, a means of curing the mother, neither is its removal the object of the operator, or the operation. Therefore, the killing of the fetus in this case is indirect, not direct. The fetus might be removed from such a uterus, and the danger to the mother's life would still endure. It is not the presence of the fetus in the uterus that endangers the mother's life, but it is the presence of the *myomata*. The *myomata* are no part of the pregnancy. Therefore, in the total excision of the uterus, it is not the pregnancy that is attacked, but the myomatous uterus. Hence, by the operation, the *myomata* are attacked directly, and the pregnancy indirectly.

Such *myomata* might develop in the non-pregnant uterus. Should they develop in the non-pregnant uterus, to such an extent as to endanger the mother's life, no one would question the right of the mother to request the total excision of the uterus, as a means

of saving her life. Therefore, the condition of pregnancy does not deprive the mother of her right to have a myomatous uterus removed, when its presence endangers her life.

(See pp. 96 to 101.)

(See "Crux of Pastoral Medicine," pp. 114 to 128.) Upon this subject, Dr. O'Malley in "Ethics of Medical Homicide" (pp. 147, 148, 149), writes as follows:

"Fibroids, called also *fibromyomata, fibromata,* and *myomata,* in the uterine muscle or *adnexa,* commonly enlarge during pregnancy, and if they are big enough, and low in the pelvis, may block the parturient canal. These tumors may suppurate, grow gangrenous, or take on a red degeneration; they may cause abortion, peritoneal adhesions, pain, or hemorrhage; simulate threatened abortion; bring on retroflection of the uterus, *placenta praevia,* abnormal presentations, sometimes weak pains, or pains so strong as to rupture the uterus, and they may check contraction after delivery, so as to start hemorrhage. They may so sink the uterus as to incarcerate the *placenta* and cause *sepsis.* The percentage of degeneration in fibroids, taken generally, is 22, according to William Mayo.

"The majority of women who have *myomata,* go on to delivery without trouble. In some, there is much pain, or hemorrhage, and these conditions may finally oblige the obstetrician to operate, but the operation should be deferred as long as possible. Where there are signs of *necrosis* of the tumor, operation is

necessary at once to prevent *sepsis*. Removal of a *myoma* during pregnancy does not always cause abortion. The statistics are that about 83 per cent. of those operated upon are removed without abortion. in the Mayo Clinic, fourteen cases of degenerating fibroids in pregnant wombs were removed, and the majority went to term. The removal is always a very bloody operation, and it requires great surgical skill. Where enucleation of the tumor alone was intended, it may finally become necessary to amputate the uterus to stop hemorrhage.

"Sometimes the fetus is so involved with a dangerous *myoma*, that the enucleation of the tumor will kill, or hasten the death of, the fetus. When, in such a complication, it is evident that the life of the woman depends on the immediate removal of the tumor, yet a second, but evil, effect follows from the operation, namely, the unavoidable death of the fetus, the removal is morally licit, provided the operator has the proper intention. The death of the child as an effect, in this case, is only indirectly voluntary from the physical point of view, and only permissively voluntary from the moral aspect."

Myomata of the Pregnant Uterus, not Endangering the Mother's Life

Question 31: If, during pregnancy, *myomata* are discovered in the pregnant uterus, but their presence

will not endanger the mother's life before the fetus is viable, is it lawful to excise the impregnated uterus before the term of viability.

Answer: No, it is not lawful.

While to excise the pregnant uterus, in such a case, would only indirectly cause the death of the fetus, nevertheless, such excision of the uterus would be unlawful on the principles laid down above. (Pp. 98 to 101).

To perform an act, good in itself, that has two effects, one good and the other evil, one of the necessary conditions required for lawfully performing the act is, that the good effect intended is at least as important as the evil effect permitted. This condition is not fulfilled in the case involved in the question. The question supposes that the mother's life will not be in danger before the child is viable; hence the evil effect of the operation—the death of the child,—is greater than the good effect,—the relief of the mother, whose life is not in danger. It is, therefore, unlawful to kill even indirectly a child in such a case.

Carcinoma of the Pregnant Uterus

Question 32: If carcinoma of the uterus develops during pregnancy, and the mother's life is thereby endangered, before the fetus is viable, is it lawful to excise totally the pregnant uterus, if the physician judges that such a course will save the mother's life?

Answer: Yes, it is lawful.

The killing of the fetus that results from this operation, is an indirect killing. The death of the fetus is neither intended, nor directly sought, but it is permitted to happen.

(See pp. 96 to 101)

Dr. O'Malley treats this subject at length in the "Ethics of Medical Homicide" (pp. 150 and 151) as follows:

"Cancers of the *cervix uteri* are always malignant and cause death, if they are not removed before they have gone on to *metastasis*. As this tumor commonly appears after the child-bearing age, it is rare in pregnancy; the ordinary ratio is one in 2000 deliveries, but De Lee saw only one in Chicago in 16000 consecutive labors. Abortion occurs in from 30 to 40 per cent. of the cases. Spontaneous rupture of the uterus may happen, and *placenta praevia* is frequent relatively. Pregnancy hastens the growth and spread of cancer very much. Eight per cent. of the women die undelivered; and 43 per cent. die during labor or immediately afterwards. Of all uterine cancers, 80 per cent. are cervical.

"The diagnosis should be as certain as possible. Rarely, nodules which are not cancerous appear in the cervix during pregnancy, and these are to be examined microscopically. Snipping out a piece of the nodule for examination does not cause abortion. Vaughan, of Michigan University, who is a skillful

and careful observer, said that in an investigation of 200 cases of cancer, upon which more than 30,000 differential blood counts were made, he discovered a method of diagnosing the operability of a cancer as follows: He makes a blood count and then injects intraperitoneally one c.c. of placental residue. The next day he begins a series of blood counts, and if the number of polymorpho-nuclear cells decreases, the case is operable, no *metastasis* has occurred; if there is no change in the number of the polymorpho-nuclears, or an increase, with a corresponding decrease of the large mononuclears, the case is inoperable, *metastasis* has begun.

"In cancer of the *cervix,* operability does not mean curability always. Inoperability signifies that the woman has no chance at all for life, and that it is useless to do anything. Operability means that she has one chance in four, and that it is worth while taking the chance. The following conditions may be met:

First, the case may be operable, and the child inviable.

Second, the case may be operable, and the child viable.

Third, the case may be inoperable, and the child inviable.

Fourth, the case may be inoperable, and the child viable.

First Case

"In the first case, the supposition is, that the case is operable, but the child inviable. To save the woman, the uterus, with its *adnexa,* must be removed, and this, of course, kills the fetus. The case differs from the enucleation of a gangrenous *myoma,* which involves the death of an inviable fetus. In the *myoma* case, the woman has practically every chance for her life through operation; in this cancer case, the woman has only one chance in four, as 75 per cent. of such operations fail through recurrence of the cancer.

"The child has about one chance in two of going on to viability, owing to the tendency to abortion, if no operation is done; but the mother loses her chance for life, if the operation is not done at once, as the cancer will spread beyond cure. Zweifel has seen such a growth extend a finger's breadth in one week. The one chance in four, in immediate operation, gives the mother a solid ground for hope, and the probability is sufficient, in my opinion, to permit the operation, with a permissive loss of the fetus."

(See p. 96 to p. 101, and also, Question 30 and Answer, p. 117)

Second Case

"In the second case, the cancer is operable, and the child viable. The child should be at once delivered

by cesarean section, and the uterus with its *adnexa* removed."

Third Case

"The third case is that of an inoperable cancer and an inviable child. There, the operation should be deferred, if possible, until the child becomes viable."

N. B. If the case is inoperable, there can be no adequate reason for any operative interference before the fetus is viable, because, as Dr. O'Malley has said above: "Inoperability signifies that the woman has no chance at all for life, and that it is useless to do anything."

Fourth Case

"The fourth case supposes the cancer is inoperable, but the child viable. In the interest of the child, immediate cesarean section is the best thing to do; it is much better than waiting until term. At term, this operation will have to be done anyhow, and the earlier it is done, the better the woman can stand the strain. There is a risk that she will die from the first operation done to deliver the viable child, but she may licitly take this risk, as she might licitly run into a burning house to save a child, even if not her own. She may also licitly refuse the first operation."

Accidental Hemorrhage—Abruptio Placentae

Question 33: In a case of severe "Accidental Hemorrhage," due to the premature complete separation of the normally implanted *placenta,* occurring before the fetus is viable, is it lawful to empty the uterus?

Answer: Yes, it is lawful.

Concerning *"Abruptio Placentae"* or "Accidental Hemorrhage," De Lee writes as follows:

"Up to 1664, all hemorrhages occurring during pregnancy were considered as due to premature detachment of the *placenta* from its supposed invariable site, the *fundus uteri.* At this time, Paul Portal proved that the *placenta* could be attached to the *cervix* at the internal *os.* Rigby in 1775, differentiated between cases of detachment of the *placenta,* situated above the zone of the dilatation of the uterus, and those below that zone. He said, that in the latter class of patients, owing to the fact that the *placenta* must necessarily separate to allow the passage of the child, hemorrhage was 'unavoidable,' while in the former, the hemorrhage is only 'accidental to the separation of the *placenta.*' 'Accidental hemorrhage,' a term still in use, especially by British authors, means the premature separation of the normally implanted *placenta.* 'Unavoidable hemorrhage' is a term seldom used, but it means *placenta praevia,* the development of the *placenta* in the zone of dilatation.

The author suggests the term *"abruptio placentae,"* to take the place of the cumbersome, generally used term, and to go with the short expressive *"placenta praevia."* Abruption of the *placenta* means a forcible tearing up of the organ from its normal site, and in reality is an abortion at or near term. Clinically, it is usually easy to differentiate between *placenta praevia* and *abruptio placentae,* but the author is convinced that many of the milder cases of accidental hemorrhage are due to the detachment of the *placenta,* situated low in the uterus, but just above the upper boundary of the zone of dilatation. The case partakes then of the characteristics of both conditions." (De Lee, p. 437.)

De Lee then proceeds to treat this subject at length and thoroughly. With reference to diagnosing this condition, he gives in detail the symptoms and signs by which a differential diagnosis may be made between *"Abruptio Placentae"* and *"Placenta Praevia,"* and between *"Abruptio Placentae"* and the rupture of the uterus.

Fortunately, cases of "accidental hemorrhage" due to *"abruptio placentae,"* the premature separation of the normally implanted *placenta,* are exceedingly rare before the seventh month of gestation. De Lee says: "It occurs oftenest at the onset of, or during labor, at term, but it may occur during the last twelve weeks of pregnancy." (De Lee, p. 437.)

It must be carefully noted that Question 33 ex-

pressly states that the *"accidental hemorrhage"* is due to the premature complete separation of the normally implanted *placenta*, because if the diagnosis indicates that the "accidental hemorrhage" is due to a partial separation of the normally implanted *placenta* before the child is viable, it is not lawful to empty the uterus, because to do so, would be to procure direct abortion. A partial separation of the normally implanted *placenta* does not necessarily imply the death of the fetus, and where a living fetus is involved, it is never lawful, for any reason whatever, to empty the uterus before the term of viability.

The affirmative answer to Question 33 is based on the fact that in a case of severe accidental hemorrhage, due to the premature complete separation of the normally implanted *placenta,* occurring before the seventh month of gestation, the inviable fetus dies within about ten minutes after the separation of the *placenta* takes place. Hence the question as presented does not involve the removal of a living, inviable fetus from the uterus, and, for this reason, it is lawful to empty the uterus under the circumstances. Upon this subject, Dr. O'Malley writes as follows: "When the *abruptio* takes place before the seventh month of gestation the fetus will die in about ten minutes, whether in the uterus or outside it; no matter what method might be adopted to empty the uterus, the child would be dead before delivery. The diagnosis would have to be made, and instruments prepared, and this would

take up more than ten minutes of life left to the fetus. It is necessary to get the fetus out, to stop the bleeding of the open sinuses by contraction of the uterus.

"The removal of the fetus here is not like an artificial abortion. In abortion, the abortionist separates the *placenta* from the uterine sinuses and so kills the fetus; the removal from the uterus is secondary to that separation which kills. The common notion of moralists that death is caused in abortion by taking the child out of the uterus is inexact—tearing loose the *placenta* is the real cause. In a removal of the fetus after an *abruptio placentae,* the death of the fetus is not caused by the physician at all, but by the force that effected the *abruptio.* As the child will be dead before sufficient dilatation of the cervix to deliver it can be attained, there is no objection to beginning the delivery as soon as the diagnosis is clear." ("The Ethics of Medical Homicide," pp. 145–156.)

It must be carefully noted that the above passage refers exclusively to cases where the hemorrhage occurs before the child is viable. In cases where the term of viability had been reached, a small percentage of the children survived the effects of the hemorrhage.

De Lee gives some statistics as follows: "Goodell, in his 106 cases, found 54 maternal and 100 fetal deaths, but he collected only the critical ones, mostly of the concealed hemorrhage. Later writers include the mild and more common abruptions, and the mortality is correspondingly less.

"Still, the accident is one of the gravest with which the obstetrician has to deal, and it is safe to say that one-half of the women and 95 per cent. of the babies in complete detachments with concealed hemorrhage will die, while a larger proportion will be saved with partial detachment and under skilful treatment." (De Lee, p. 442.)

SECTION IV

Ectopic Gestation

In this section are treated questions involving cases of "Ectopic Pregnancy or Gestation."

Definition of Ectopic Gestation

"Ectopic pregnancy or gestation, means a gestation which occurs outside of the cavity of the uterus. Extra-uterine gestation is the term more commonly used, but this would exclude from the study those cases where pregnancy develops in the interstitial portion of the tube." (De Lee, p. 381.)

Various Forms of Ectopic Pregnancy

"An *ovum* may be fertilized and remain at any point of its passage from the ovary to the uterus. The most common sites of its nesting are the tube, its median or isthmial, its ampullary, its uterine or interstitial, portions, in the order named, and lastly, the ovary. Primary abdominal pregnancy has been reported on the posterior fold of the broad ligament and on the *omentum,* but it is of such exceeding rarity that it need only be mentioned. Hecker considered it very common, but these were secondary abdominal

pregnancies. Pregnancy has developed in a *sinus* possibly with a piece of Fallopian tube, following vaginal hysterectomy, and also in the stump of a tube after a partial salpingectomy. Pregnancy may occur in a closed accessory horn of the uterus, and on the *fimbria ovarica* of the Fallopian tube. In the latter instance, one speaks of a tubo-ovarian form. As the *ovum* distends its container, other structures are encroached upon, adhesions formed between them, and the primary topography of the gestation is modified. When the tubal wall bursts,—the fetus escaping into the free abdominal cavity or into a mass of preformed adhesions,—we speak of tubo-abdominal pregnancy; if the rupture occurs in the lower portion of the tube, between the folds of the broad ligament, an intra-ligamentous sac is formed; if the sac which is formed in an interstitial pregnancy bursts into the uterus (rare), we speak of tubo-uterine; if the ovarial pregnancy goes toward term, it almost always becomes ovario-abdominal—these are the secondary forms, and clinically, as well as anatomically, hard to distinguish from each other." (De Lee, p. 381.)

Such are the definitions and the brief outlines of the various forms of ectopic gestation, as given by De Lee. He further states that "No pelvic condition gives rise to more diagnostic errors."

"Between 1889 and 1896," writes Dr. O'Malley, "Haines found 40 operations for ectopic gestation, done after the seventh month of pregnancy, with 10

maternal deaths. Of the children, 27 survived the operation, from a few moments to fifteen years. Sittner, in 1903, compiled from the medical reports 142 cases of viable ectopic fetuses, and Essen found 25 additional cases. Since Essen's article, more have been reported, about 173 to my knowledge, but the number is considerably larger." ("The Ethics of Medical Homicide," p. 126.)

Moral Principles Which Apply to Cases of Ectopic Gestation

The moral principles stated and explained in pp. 28 to 56 inclusive, apply with the same force to an ectopic fetus as they do to an intra-uterine fetus. An ectopic fetus is an innocent human being, and hence it possesses all the essential rights of an innocent human being. Therefore its right to life is just as sacred and inviolable, as that of an intra-uterine fetus. It follows as a consequence from this, that all the principles that apply to the direct and indirect killing of an intra-uterine fetus, apply with equal force to the direct and indirect killing of an ectopic fetus.

(See pp. 28 to 56, pp. 96 to 101, and answer to Question 17, and pp. 79 to 95)

Writing upon the subject of "Ectopic Conceptions," Father Klarmann remarks: "It may be objected that ectopic conceptions result as by accident, and with-

out any fault of the mother; therefore, although the mother may be willing enough to bear out a natural conception, even under great difficulties, still, she should not be asked to bear the consequences of 'misguided nature.' "

To which he replies:

"1. The child is as much the victim of 'misguided nature' as the mother, and it, too, deserves some consideration, for it is a human being despite its unfortunate position.

"2. The child is in the same danger as the mother, and that not from choice, but from the indisposition of the mother; this indisposition may, or may not, result from an error of the mother, or from an error of nature, which at some time or other, was held up in its natural function; but this is not the fault of the child, and therefore, the innocent fetus must not be burdened with the sins of its progenitors, or with the mistakes of misdirected nature.

"3. Even if the right to the abode which it occupies, be denied the child in such pregnancies, still, it enjoys a higher right than the mere accident of position; namely, the right to life, which it receives from God as the first natural endowment, and which, therefore, is inviolable per se." ("Crux of Pastoral Medicine," pp. 104, 105.)

The "Unjust Aggressor" argument does not apply to the ectopic fetus, any more than it does to an intrauterine fetus. In other words, such an argument is

without any rational basis as a reason for killing an ectopic fetus.

Teaching of the Church

The Church clearly recognizes that, under the natural law, the ectopic fetus has an inviolable right to its life, and hence the Church has issued a special decree upon this point.

In answer to the question: "Is it ever lawful to remove from the maternal pelvis an ectopic fetus which is still immature; that is, which has not completed the sixth month after conception?" the Congregation of the Holy Office replied by a decree dated March 5, 1902, as follows: "No, according to the decree of May 4, 1898, which prescribes that the life of the fetus and the mother must as far as possible be safeguarded. As to the time, according to the same decree, the questioner will remember, no premature delivery is permissible unless it is effected at such a time, and by those methods, which in ordinary circumstances safeguard the life of the mother and the fetus."

Teaching of Obstetrical Works

The common teaching of obstetrical works is that, as soon as the diagnosis of ectopic gestation is positively made, the ectopic fetus should be removed, regardless of whether the fetus is viable or not. Since

the removal of an inviable ectopic fetus means its death, such teaching is contrary to the natural law, and consequently it is morally unjustifiable.

Removal of Inviable Ectopic Fetus

Question 34: In a case of ectopic pregnancy, in which the presence of the fetus is regarded as endangering the mother's life, is it lawful to remove an inviable ectopic fetus?

Answer: No, it is not lawful. Such a removal would be a direct killing of the fetus, and is, therefore, forbidden, on the same principles on which direct abortion and embryotomy are forbidden.

(See pp. 132 and 133, pp. 79 to 95, pp. 28 to 57)

Unruptured Tubal Pregnancy

Question 35: In a case of ectopic pregnancy, which has been diagnosed as a case of unruptured tubal pregnancy, is it lawful, before the term of viability, to remove the unruptured tube with the living fetus, as a means of forestalling the danger to the mother's life, upon the rupture of the tube?

Answer: No, it is not lawful. Such a removal is a direct killing of the fetus, and is therefore forbidden.

(See pp. 131 to 135, pp. 79 to 95, pp. 28 to 57)

Inviable Ectopic Fetus Discovered During Abdominal Operation

Question 36: If a surgeon operating for appendicitis, or for the purpose of curing some other disease not directly proceeding from pregnancy, discovers an ectopic fetus not yet viable, is it lawful for him to remove it?

Answer: No, it is not lawful.

Such a removal would be a direct killing of the fetus, and therefore is not permissible. It matters not in what form the ectopic pregnancy is discovered, it is not lawful to remove an inviable ectopic fetus as a means of saving the mother. It may be that, in the course of an operation for appendicitis, or some other abdominal trouble, a pregnant tube is discovered which has not yet ruptured, but which gives every indication that it will rupture in the very near future. While such a tube adds a new element of danger to the abdominal operation presented in the question, nevertheless, this danger, no matter how great, does not justify the direct killing of the fetus, involved in the removal of the unruptured tube.

(See pp. 132 and 133, pp. 79 to 96 pp. 28 to 57)

Viable Ectopic Fetus Discovered During Abdominal Operation

Question 37: If a surgeon, operating for appendicitis, or for the purpose of curing some other disease

not directly proceeding from pregnancy, discovers an ectopic fetus that is viable, but has not reached the full term of gestation, is it lawful for him to remove it?

Answer: Yes, it is lawful.

Although the fetus has not reached the full term of gestation, nevertheless, the danger to the mother's life under the circumstances is such as to justify the removal of a viable fetus.

(See p. 98 to p. 101)

Doubtful Case Concerning an Enlarged Tube

Question 38: If a surgeon, operating for appendicitis, or for the purpose of curing some other disease not directly proceeding from pregnancy, discovers an enlarged Fallopian tube, and finds it impossible to determine whether the enlargement is due to an inviable ectopic fetus, or a hematosalpinx, or some similar cause, is it lawful for him to remove the tube, if he judges that its condition constitutes a danger to the woman's life?

Answer: Yes, it is lawful.

While some competent surgeons maintain that it is always possible to make a differential diagnosis in such a case as is presented in the question, others maintain that it is not possible.

Where an honest doubt exists, the mother is to be

given the benefit of the doubt. As implied in the question, the very existence of the fetus is doubtful. If it does exist, its death is neither intended nor made a means to the end to be accomplished by the operation. The operation is good in itself, because it proposes to remove what appears to be a diseased organ, and not certainly an ectopic tube. Finally, the good effect intended is the mother's safety, to which she has an undoubted right, and this good effect overbalances the evil effect, the possible death of the child, whose very existence is doubtful.

(See pp. 96 to 101)

Ruptured Tubal Pregnancy

Question 39: In a case of ruptured tubal pregnancy with hemorrhage, which endangers the mother's life, is it lawful to perform celiotomy, ligate the mother's arteries and remove the fetus?

Answer: Yes, it is lawful, whether the fetus is viable or not.

In this case, it is not the presence of the fetus that endangers the mother's life, but it is the hemorrhage resulting from the rupture of the tube. The direct object and end of the operation is to check the hemorrhage. The checking of the hemorrhage will indirectly result in the death of the fetus. Here the death of the fetus is in no sense made a means of

saving the mother, but it is permitted to happen as a result of checking the mother's hemorrhage.

(See pp. 96 to 101)

The analysis of this case is given by Dr. O'Malley in "Essays in Pastoral Medicine" as follows:

"1. The action is a stopping of a fatal hemorrhage in a woman, and possibly, though not certainly, an indirect, incidental hastening of a fetus's inevitable death.

"2. The object of the action is the *hæmostasis,* which is good, and the possible indirect hastening of the fetus's death, which is evil, but, as we shall see, an excusable evil.

"3. The end of the action is to save the mother's life—a good end.

"4. The circumstances are, (a) that possibly, through mere luck, the woman's condition is not necessarily hopeless;—a few women have escaped in this seemingly imminent peril—but that chance of escape is not soundly probable; the stronger probability by far is on the side of a fatal issue; therefore the chance for escape may be neglected, and the woman's case may be regarded as hopeless if operation is foregone.

"(b) The quickest possible work on the surgeon's part is necessary, and there is no time or chance to examine the foetus's condition, before tying the maternal arteries. Before he opens the mother's abdomen, he can tell nothing whatever of the foetus's condition,

but the probability is all in favour of the fact that the foetus is already dead or moribund.

"(c) The means are coeliotomy, and the ligation of the uterine and ovarian arteries to stop the mother's bleeding. This ligation, in the contingency that the foetus is still attached to the Fallopian tube, will also shut off the blood from the foetus, yet the uncertain shutting off of the foetal blood-supply is not intended by the surgeon as a means toward his end, in any degree direct or indirect, but it is an evil circumstance associated with the action, which may hasten the foetal death—even here the hastening is uncertain.

"5. The action has two effects,—one, the saving of the mother, is directly intended and evidently good; the other, the possible, indirect hastening of the foetus's death, may or may not be evil. The moral centre of the whole case is this possible hastening of the foetus's death. If that possible hastening is licit, the whole action is licit; if it is not permissible, it will vitiate the entire action.

"Suppose that there is no doubt that the ligation of the maternal arteries, in this case, really hastens the foetus's death some minutes; it would still be an indirect volition. The cutting off of the foetal blood is a fact associated with the means, not a means direct or indirect toward the end, which is to save the mother —the means to save the mother is the stopping of her bleeding."

Diagnosis Uncertain as to Ectopic Gestation or Pelvic Tumor

Question 40: A surgeon, after consultation, does not know whether the growth in a woman's pelvis is a tumor or a sac containing an extra-uterine fetus. May he operate at once, or is he obliged to put off the operation until a time when certain signs of pregnancy should be present to establish a diagnosis of gestation, or the lack of these signs to establish a diagnosis of tumor?

Answer: The question, as proposed, requires a double answer.

(1) If, under the circumstances mentioned in the question, the woman's life is actually in danger, the surgeon may operate.

(2) If her life is not actually in danger, he must defer the operation until such time as he will be able to make a differential diagnosis between ectopic pregnancy and tumor.

The first part of this answer is based upon the principle that the mother's certain right to her life should prevail against the probable killing of a fetus, whose very existence is doubtful. Hence, under the conditions mentioned in the question, if the mother's life is actually in danger, the surgeon may operate, but here it must be carefully noted: first, if, upon opening the pelvic cavity, he still has an honest doubt whether the growth is a tumor or a sac containing

an ectopic fetus, he is free to remove it; secondly, if, on opening the pelvic cavity, it is evident that the growth is not a tumor, but a sac containing a living, inviable, ectopic fetus, he is not free to remove it. This latter case is covered in Question 41.

The second part of the answer to Question 40 is based on the following reason:

If the growth in question is really a tumor and not an ectopic fetus, it is either malignant or it is not malignant. If it is malignant, a competent surgeon should be able to make a differential diagnosis between a malignant tumor and an ectopic pregnancy. If it is not malignant, a sufficient delay to await the appearance of signs of pregnancy, if such a condition exists, will not add materially to the danger to the mother's life from a non-malignant tumor.

Operation in Case of Uncertain Diagnosis of Ectopic Pregnancy

Question 41: A surgeon after consultation is unable to determine whether a growth in a woman's pelvis is a malignant tumor, or a sac containing an extra-uterine fetus, but he proceeds at once to perform celiotomy, and after he opens the abdomen, he finds a sac containing a living, inviable, ectopic fetus, instead of a tumor;—is it lawful for him to remove the sac with the living, ectopic fetus?

Answer: No, it is not lawful, because such a removal would be a direct killing of the fetus. The

mistaken diagnosis, and the celiotomy, which adds a new danger to the mother's life, have no effect whatever upon the inherent right of the fetus to its life. Therefore, no matter how grave a danger may result to a mother's life from a mistake of a surgeon, such a mistake cannot justify the removal of an inviable, ectopic fetus, as a means of removing the danger to the mother's life.

The question as proposed does not imply ectopic gestation complicated by hemorrhage.

(See pp. 79 to 96)

Uncertainty Whether an Ectopic Fetus is Living or Dead

Question 42: In the event a surgeon diagnoses a case of ectopic gestation, but is unable to determine whether the fetus is alive or dead, is he justified in operating without further delay?

Answer: No, he is not justified.

Such an uncertainty is not sufficient justification for immediate operative interference. Under the circumstances, the fetus must be supposed to be alive, until there are evident signs to the contrary. If in the case presented in the question, a surgeon were to proceed to immediate operation and find a living fetus, it would be unlawful for him to remove the living fetus, as has been stated in answer to the preceding question, notwithstanding the fact that he would have added a new danger to the mother's life by the opera-

tion. If the fetus is dead, and its presence endangers the mother's life, evident symptoms will be present, that will enable a competent surgeon to diagnose such a condition.

Under the heading "Diagnosis of the Life and Death of the Fetus," De Lee writes as follows: "Without positive evidence to the contrary, a fetus is considered alive. While we can easily assert that the child lives, we can less readily be sure that it is dead." He then proceeds to give in detail ten symptoms and signs of fetal death. (De Lee, p. 265.)

SECTION V

Mutilation

In this section are treated questions which involve the mutilation of the human body.

Mutilation may be defined as the removal of some member requisite for the integrity of the human body. Such is the sense in which the word is generally understood, but when viewed in the light of modern surgery, the definition imperatively demands further extension and qualification. With the application of modern surgical methods, it is possible gravely to mutilate a person without actually removing any member requisite to the integrity of the human body.

For this reason, the definition of mutilation should include, "the inhibition of the function of a distinct organ through a wound."

Consequently, mutilation may be accurately defined as follows: "Mutilation is the removal of some member requisite for the integrity of the human body, or it is the inhibition of the function of a distinct organ through a wound."

Dr. O'Malley in his "Ethics of Medical Homicide" writes as follows:

"A slight mutilation, in the sense of the term as commonly used, can be any permanent effect of a wound, bruise, or similar cause, from a mere scar to

an amputation—or any other injury whereby any member of the body is rendered unfit for normal action. That the causal wound or injury is trivial in itself, apart from its effect, as in vasectomy, has little or no direct bearing on the morality of the mutilation. It is possible to have a very gross mutilation without extensive wounding. We can blind a man permanently by putting the point of a fine cambric needle one-twentieth of an inch within the pupil." ("Ethics of Medical Homicide," p. 260.)

Principles Governing the Morality of Mutilation

"Any notable mutilation inflicted upon oneself, is akin to the malice of suicide, and when perpetrated upon another, it is related to homicide. The dominion over the members of the body, as over the whole body, belongs to God alone. Man is constituted by his parts, members, taken together, and if he were master of his members he would be master of himself. Again, each member of the body is naturally united to that body and ordained for organic functions; so it is wrong to render these members unfit for their natural function, or to separate them from the body, unless such actions are necessary for the preservation of life itself. Although man is not master of himself, he is the administrator of himself, and therefore, when the amputation of any member is

necessary for the preservation of life of the whole body, it is licit to subordinate this part to the good of the whole.

"A direct mutilation is one intended as an end, or as a means to an end; it is a voluntary and free act. An indirect mutilation is one in which the mutilation is the natural effect of the act, but the intention of the agent is directed toward another end. The mutilation follows indirectly from the activity of the will, but there is a satisfying proportion between the accidental effect (the mutilation) and the end intended. In such an act there are two effects which follow the causal act *aeque immediate,* or directly (not indirectly, that is, not all from the other effect, but each immediately from this cause); one effect good, (to save life, avoid unbearable pain or the like), the other evil, (the mutilation), but the good effect is the end intended, the evil effect is reluctantly permitted. Such an act is licit, provided the usual conditions of the double effect are present, that is:

"1. The action that is the cause of the good and bad effects must be, itself, good or indifferent morally.

"2. The good and bad effects must each be an immediate result of the causal act; the good effect may not be so subordinated to the evil effect, as to be obtainable only through the evil effect.

"3. The bad effect must not be intended, either immediately or remotely; it may, at most, be tolerated as unavoidable.

"4. There must be a sufficiently grave reason for the act.

"Indirect mutilation may be licit, when the evil to be avoided is proportional to the mutilation. Direct mutilation, where there is one direct effect of, say, the surgical operation, namely, to remove the somatic organ, is not licit, except for the good of the whole body; and that good of the whole body must be juridically equivalent to the damage done the body by the mutilation. There is to be a direct effect in such mutilation, which is the good of the whole body.

"All direct mutilation, unless for the good of the whole body, implies deordination; it offends against the supreme dominion of God, who reserves to himself, as Creator, ownership of human life and its organs. As we may not destroy life, which belongs to God, we may not amputate a member to suppress any vital function. The exception which permits us to mutilate a member or organ is, as has been said, the adequate good of the whole body. The reason of this is, that man is the administrator of his members, to the good of the whole person. Each member is not for itself, but for the whole body." ("The Ethics of Medical Homicide," pp. 26–27.)

(See p. 96 to p. 101)

Grave Mutilation

Question 43: What is a grave mutilation?

Answer: A grave mutilation may be defined, as one that results either in the removal of a distinct member of the human body, or in "the inhibition of the function of a distinct organ through a wound."

Lawful Grave Mutilation

Question 44: Is it ever lawful to permit a grave mutilation of the human body?

Answer: Yes, it is lawful, whenever such a procedure is deemed necessary, either to avert a present danger to the life of the individual, or to restore the general health of the whole body.

(See pp. 145 to 149, and pp. 98 to 101)

Sterilization in General

Question 45: Is it ever lawful to perform a surgical operation or administer any treatment, in which sterilization is directly intended either as an end or as a means to an end?

Answer: No, it is not lawful.

Sterilization, when directly intended as an end or as a means to an end, is immoral, and no ultimate purpose, however good, can morally justify it. The above answer is based entirely on the phrase, "directly intended." As will be shown in the answers to some of the questions in this section, sterilization may be a direct result of a surgical operation or of some treat-

ment, and yet be morally permissible. But it is to be carefully noted that, while in such cases sterilization is a direct result of the operation or treatment, it is not "directly intended," but simply permitted.

(See pp. 145 to 149, and pp. 98 to 101)

Sterilization to Avert a Future Danger

Question 46: Is it ever lawful to perform any surgical operation, whose immediate end and purpose is the sterilization of a man or woman, even though the ultimate purpose of the operator is to prevent a future danger to the life of the person sterilized?

Answer: No, it is never lawful.

(See pp. 145 to 149 and pp. 97 to 101)

Here there are not two effects, one good and the other evil, following immediately from the same causal act, but two evil effects, namely, sterilization and mutilation, following immediately from the surgical operation.

Furthermore, the remote good effect intended—the prevention of a future danger—does not follow immediately from the operation, but is sought and accomplished by means of the evil effect, sterilization.

By the proposed operation, the bad effect is not tolerated as unavoidable, but is actually intended, as a means of accomplishing the remote effect.

In all these features, any surgical operation such as is proposed in the question, violates the principles

which make mutilation morally lawful, and therefore, such an operation is not morally lawful.

Sterilization, no matter by how slight an operation it may be accomplished, is a grave mutilation, because it is the inhibition of a most important function of a distinct organ of the human body.

Sterilization is evil, when it is sought as an end in itself, or as a means to an end, because it is opposed to the principal intrinsic end and good of matrimony, which is the generation of offspring. It is therefore so repugnant to the natural law, that no good end can justify it, where it is made an end in itself or a means to an end. For this reason, the Church condemns all surgical operations performed for the purpose of sterilizing either men or women. In answer to the direct question, "Is any active or passive procedure licit, which is undertaken with the express end of sterilizing a woman?" the Congregation of the Holy Office replied by a decree under date of May 22, 1895, that any such procedure is not lawful. The same answer applies with equal force to the sterilization of men.

Hence the following operations, and all kindred operations, which have sterilization for their immediate end, no matter what their ultimate purpose might be, are forbidden:

First, Vasectomy applied to both *vasa deferentia.* Vasectomy is the surgical removal of the *vas deferens,* or of a portion of it. The *vas deferens* is the ex-

cretory duct of the testicle, passing from the *testis* to the ejaculatory duct.

Second, Vasotomy applied to both *vasa deferentia.* Vasotomy is the incision of the *vas deferens.*

Third, Oophorectomy, or Ovariotomy applied to both ovaries. Oophorectomy is the surgical removal of an ovary. In this connection Ovariotomy is used in the same sense.

Fourth, the ligation, resection, or removal of both Fallopian tubes.

Fifth, the removal of the uterus.

Sixth, the application of X-Rays or of radium treatment, for the purpose of causing sterilization. X-Rays and radium treatments are now applied to the sterilization of women, to prevent future pregnancies that might either endanger their lives or seriously impair their health, but such application of X-Rays and radium treatments is wholly immoral.

The distinct function of the ovaries can be completely destroyed by radiation, and hence, in such cases, we have a grave mutilation without any surgical interference.

Many medical authorities give no consideration whatever to the morality of sterilization, and even go so far as to advocate that sterilization should be made a part of every operation for cesarean section, in order to forestall a danger to the mother's life from future pregnancy.

De Lee gives more consideration to this phase of the

subject than is generally found in works on obstetrics. Under the caption, "Sterilization with Section," he writes as follows:

"Should the woman be sterilized to prevent future pregnancies? Authorities differ between wide extremes, and, in deciding, one must consider the dangers of subsequent pregnancies and labors, and the necessity for consecutive cesarean section.

"If the woman has tuberculosis, chronic nephritis, osteomalacia, or any disease which in itself is a contra-indication of pregnancy, she should be sterilized. Any one who admits the propriety of inducing abortion for such conditions, must admit the above postulate. Contracted pelvis is not allowed in this category.

"The danger of rupture of the uterine *cicatrix* is no indication, because we can avoid this by properly sewing the uterus, by placing the patient in a good maternity hospital, several weeks before labor, and operating before pains set in.

"If the first section is done for *eclampsia, placenta praevia, abruptio placentae,* prolapse of the cord, faulty mechanism of labor, pelvic tumors, in the absence of other indications the woman should not be sterilized. If the woman has a large family, the question is discussable, but if there is only one child, and that one, weak or deformed, it is better not to sterilize her.

"If the cesarean operation is done for contracted pelvis, I earnestly dissuade the patient from such a procedure at the first section, pointing out the fact of

the safety of subsequent operations, the possibility of the death of the only child, and the unhappiness of a one-child family. At the second cesarean I willingly sterilize, if requested, although lately, since the mortality has been so much reduced, I often suggest a third operation.

"For many years the ethics of sterilization have been debated. Green created an extensive discussion of it at the 1903 meeting of the American Gynecologic Association, taking an extreme negative position. Most American, English, and Continental authors concede the right of decision to the mother and her family, after they have been given a fair presentation of all the facts, a position which I also take. By following the Golden Rule I have no difficulty in arranging a satisfactory course in these matters." (De Lee, p. 996.)

From a careful reading of the above it is evident that the most plausible reason that can be advanced to justify sterilization, is the danger to the mother's life from future pregnancies, and the consequent necessity of repeated cesarean sections.

Such a reason is without justification, according to the principles laid down at the beginning of this section, which are the principles of sound morality. Even if the future danger to life were absolutely certain, there could be no moral justification for sterilization as a means to forestall this certain danger. Therefore, for a much greater reason, there can be no

moral justification for sterilization as a means to prevent a future danger which is uncertain, because future pregnancies are wholly uncertain.

A good end, no matter how great the good, can never justify an evil means, such as sterilization. De Lee says: "Most American, English, and Continental authors concede the right of decision to the mother and her family." These authors cannot well concede a right which they themselves do not possess, nor can the mother exercise such a right, since the possession of this right is not granted to her by the natural law. By the natural law, the mother is not granted an absolute dominion over her body or the parts of her body. Now, every operation that has sterilization for its immediate end, implies an absolute dominion over the parts of the body; therefore, to consent to any such operation is a usurpation under the natural law, and cannot be justified on principles of sound morality.

Removal of Both Tubes, or Both Ovaries, or the Uterus

Question 47: If both Fallopian tubes, or both ovaries, or the uterus are diseased to such an extent as to endanger a woman's life, or cause serious detriment to her general health, is it lawful to remove these organs?

Answer: Yes, it is lawful.

Such removal is morally lawful, under the circum-

stances represented in the question, even though sterilization will be one of the results of the operation. But, in this case, sterilization is neither intended nor sought either as an end, or a means to an end, but it is reluctantly permitted to happen, as an unavoidable result of the operation.

The immediate end of the operation is to remove a diseased organ and thereby either to remove a present actual danger to the woman's life, or to restore her general health, that is seriously impaired by the presence of the diseased organ. The grave mutilation involved in the operation is morally permissible, since the general good of the whole body demands it.

(See p. 145 to p. 149, and p. 98 to p. 101)

Removal of Both Tubes, or Both Ovaries, When Only One is Diseased

Question 48: When only one tube, or one ovary, is so diseased as to require removal, is it lawful at the same time to remove the undiseased tube, or ovary, in order to forestall future infection that would render another serious operation necessary?

Answer: No, it is not lawful.

The only moral justification for the removal of a tube, or ovary, is that either of these organs is so diseased as to endanger a woman's life, or seriously impair her health. One of the principles, as stated above, governing the morality of mutilation, is the

following: "The good and bad effects must each be an immediate result of the causal act; the good effect may be not so subordinated to the evil effect as to be obtainable only through the evil effect." The conditions required by this principle are fully satisfied by the removal of a diseased tube, or ovary, but they are violated by the removal of an undiseased tube, or ovary, in order to prevent future infection.

In removing a diseased tube or ovary, two effects follow as immediate results of the operation; one is the grave mutilation, the other is the removal of a present actual danger to the woman's life, or the removal of a present actual cause of serious ill-health.

In removing an undiseased tube, or ovary, to forestall future infection, there is but one immediate and direct result of the operation, and this is the grave mutilation involved in the removal of the tube, or ovary, and this immediate and direct effect is made the means of obtaining an indirect and remote result, namely the forestalling of a future danger. Therefore, in the case presented in the question, the removal of an undiseased tube, or ovary, is not morally lawful.

In connection with the point raised in the question, it may be well to add here several pertinent extracts from Dr. O'Malley's excellent work, "The Ethics of Medical Homicide," in which he writes as follows:

"In cases where the gonorrheic or other bacterial infection has been chronic in the uterine *adnexa,* palliative treatment will in a certain percentage of cases

make surgical intervention unnecessary, and when such treatment does not avail, we must decide between the total removal of organs, and the partial removal. Partial removal is called conservative surgery, and the term conservative is used as a synonym of preservative. Prochownick reported 420 cases where pus in tubes or ovaries was let out extraperitoneally, and no organs were removed. Of these cases one hundred and sixty, or 38 per cent., were permanently cured. Fourteen of the one hundred and sixty, who had received only one treatment, subsequently gave birth to children, and three aborted. After a second treatment, twenty-seven remained well and three became pregnant, of whom one aborted. Olshausen, a great authority in gynecology, used the palliative treatment, and he commonly waited for nine months after the infection and until the temperature was normal. Goth reported excellent results in seven hundred cases of pelvic disease treated by the palliative method. . . ." (P. 217.)

"The presence of pus in a tube is absolute indication for removal according to gynecologists at present. Howard Kelly and others have succeeded, at times, in such cases, with conservative surgery, yet such treatment is now deemed obsolete—the dangers and failures seem to overbalance the little good effected. . . . (P. 218.)

"When a single tube is affected, the cause is seldom the gonococcus, but some other bacteria which are not

persistent. When both tubes are affected, the cause is commonly the gonococcus, and attempts at preservation then fail, as a rule. Norris, who is a reliable authority, holds that "the only cases in which a salpingostomy is justifiable is on old, non-active hydrosalpinges, and in those cases of tubal occlusion or phimosis, resulting from extratubal inflammation, such as sometimes result from appendicitis or ectopic pregnancies." (Pp. 218, 219.)

The total removal of both ovaries always has a most serious effect upon the general health of a woman; therefore, when it is at all possible to save even a portion of an ovary, this should be done.

Upon this subject Dr. O'Malley writes as follows: "The removal of the ovaries has other profound effects beside sterility. Loss of the ovaries brings on suppression of ovulation, menstruation, pregnancy, and ovarian internal secretion, various neuroses, and a tendency to insanity in certain cases. . . ." (P. 219.)

"Gordon (Jour. Amer. Med. Assoc., October 17, 1914) reported on 112 cases of oophorectomy. Of these thirty-four had had before operation various symptoms of neurasthenia, hysteria, or psychasthenia, and vague abdominal disturbances. Surgeons in each of these thirty-four cases blamed the ovaries for the symptoms; and although these organs were not diseased in any degree, the surgeons removed them. In twenty-five of these cases there was no improvement whatever; in the remaining nine there was improve-

ment for a few weeks, but complete relapse later, and finally their symptoms grew worse. The obsessions became permanent and expanded. Those women in the group who had hysterical paroxysms, began to have stronger and more frequent attacks. Several psychasthenics had to be confined in asylums for the insane. Three of the women who had complained merely of vague nervous symptoms, as pain in the abdomen, head, or back, or of constipation or diarrhea, after the oophorectomy grew irritable, highly nervous, quarrelsome, fickle, restless, showed a tendency to travel about, to complain of others; finally there was insomnia, and loss of appetite or voracity. In the remaining seventy-five cases one or both of the ovaries were diseased, but both ovaries were completely removed. All these women developed symptoms like those described above, but several grew much worse in their mental condition than the psychasthenics among the first thirty-four women. . . ." (P. 220.)

"When the ovaries must be removed for diseases like cystic degeneration or abscess, the surgeon leaves, if possible, part of an ovary, or he engrafts part of an ovary in the abdominal wound, under the skin, or elsewhere. This grafting is beneficial in many cases, but it has little or no effect in many others. The graft is absorbed and it disappears in a year or two, but before it is absorbed, it makes the onset of the surgical menopause gradual, and thus prevents much

suffering. ("The Ethics of Medical Homicide," p. 221.)

(See p. 145 to p. 149, and p. 98 to p. 101)

Removal of an Infected Uterus

Question 49: If at the time a cesarean section is performed, the uterus gives evidence of being infected, is it lawful to remove the infected uterus?

Answer: Yes, it is lawful.

Such an infected uterus is an actual and present danger to a mother's life, and therefore its removal is morally justifiable. However, there are numbers of cases on record in which mothers have completely recovered, even though the uterus was infected, but not removed, after the child had been delivered by the extraperitoneal cesarean section. Regarding results obtained by the extraperitoneal cesarean section, Dr. O'Malley writes as follows: "Before antiseptic surgery began, opening the abdominal cavity was almost always fatal, and some obstetricians tried to get the child out of the uterus, in cases where the cesarean delivery is indicated, by going in above the pelvis without opening the peritoneum. The uterus was incised towards its cervical end. This method, called extraperitoneal cesarean delivery, has been restored for use in cases where there is some infection of the uterus, and the operator wishes to save the child with-

out removing the womb. The technic is more difficult than in the classic cesarean, and the operation was not kindly received, but of late, some men are having so much success with it that it is reviving, and rightly so. Baisch says that the first eleven women he delivered by the extraperitoneal cesarean section, recovered more readily than they would from an ordinary laparotomy. In nineteen cases of transperitoneal, but cervical, section he had no trouble, and six of these were infected cases. The technic of this low incision protects the peritoneal cavity better than the classic incision, apparently. Two of the nineteen women were in slight fever, and the uterine fluids were fetid. Two *primiparae,* forty years of age, had been in labor seventy hours. Eight of the women were able to leave the clinic on the tenth day. Only one child was lost, and that was a delayed case. Hofmeier compiled 194 cases of transperitoneal cervical cesarean section with three deaths. Kustner did 110 extraperitoneal cesarean sections with no mortality. This makes 304 cases of cesarean cervical section, not the classic operation, with only three deaths, less than one per cent. mortality; and fully 50 per cent. of these cases were not surgically clean. From these statistics it is evident that the cervical operation, in the hands of competent surgeons, should be the operation of choice." ("The Ethics of Medical Homicide," p. 138.)

Speaking of total hysterectomy in connection with cesarean section, Williams writes as follows: "Total

hysterectomy is rarely indicated except in cancer of the uterus, or in occasional cases of infection." (Williams, p. 448.)

In writing upon this subject, De Lee mentions eight indications for hysterectomy, all of which imply infection, and he then adds this significant paragraph: "Much more uncertainty exists as to the propriety of removing the uterus in cases of *bacteremia,* or, at least, in cases of severe *endometritis,* and uterine *lymphangitis,* and *phlebitis,* when the infection, presumably, is still more or less limited to the uterus. There is the point. If we could tell when the infection is likely to pass the line of safety, we would know when to remove the uterus, and experience has shown that uteri are usually removed too late to do any good, and in those cases where the courageous operator has done hysterectomy early, he could never be sure that the mutilation of the patient was demanded. The operation may have killed her, or if she got well, may not have contributed to her recovery, but has rendered her sterile. My own experience with the operation is nil —I have never seen a case where I thought it could possibly save life, and in many critical cases recovery ensued without it. If a general *bacteremia* exists, no one would expect any good from the operation. Williams, Lee, and Edgar take the same position. Septic patients are the very poorest subjects for operations and anesthetics, especially chloroform (L. Guthrie), and there is no doubt in my mind but that many

puerperae annually lose their lives because of them." (De Lee, p. 882.)

(See p. 145 to p. 149, and p. 98 to p. 101)

Removal of an Uninfected Uterus

Question 50: If, at the time a cesarean section is performed, the uterus gives no evidence of being actually infected, is it lawful to remove the uterus, in order to forestall the danger of infection?

Answer: No, it is not lawful.

To remove the uterus under the circumstances proposed in the question, would be to inflict a grave mutilation, having but one immediate and direct effect, that is, the removal of an undiseased organ, whose actual condition does not constitute a present danger to the mother's life, and, furthermore, this evil effect is made the means of obtaining an indirect good result, namely, forestalling a probable future danger to the mother's life. The removal of the uterus, under the circumstances, violates the principles which make mutilation morally lawful. (See pp. 145 and 149, discussion under preceding question.)

Removal of Uterus, When Both Tubes and Both Ovaries are Removed

Question 51: If both Fallopian tubes, and both

ovaries, are so diseased as to require removal, is it lawful at such a time to remove the uterus, even though it gives no evidence of actual infection?

Answer: Yes, it is lawful.

If both tubes, and both ovaries, are removed, the uterus is liable to give future trouble from atrophy, and since, after the removal of both tubes and both ovaries, there is no further use for the uterus, the surgeon is free to remove it, if he judges that it will give future trouble from atrophy, unless it is removed.

But if both tubes are removed, but not the ovaries, the uterus should not be removed unless it is infected, because if, under the circumstances, the uterus is removed, menstruation ceases, and "the blood supply to the ovary is interfered with, so that the ovaries degenerate. The consequent artificial menopause has a decidedly injurious effect on the woman's general physical and mental health." ("Ethics of Medical Homicide" p. 223.)

(See p. 145 to p. 149, and p. 98 to p. 101)

Removal of Appendix not Diseased

Question 52: While operating in the pelvic cavity, for some reason other than appendicitis, is it lawful for a surgeon to remove an apparently healthy appendix, if he judges that unless he does remove it, it will form adhesions, and thereby render another abdominal operation necessary in the future?

Answer: Yes, it is lawful to remove it.

This answer is based on the fact that, although the appendix may be regarded as a distinct organ of the human body, in the light of our present experience its removal never seems to cause any serious inconvenience, whereas its presence, after an abdominal operation, constitutes a probable danger from adhesions that may render a second abdominal operation necessary. Therefore, under the circumstances, there is a sufficient reason for its removal.

(See p. 98 to p. 101)

SECTION VI

In this section are treated a few miscellaneous questions that were submitted for solution while this manual was in the course of preparation.

Twilight Sleep

Question 53: What are the moral aspects of the use of "Twilight Sleep" during labor?

Answer: The regular use of "Twilight Sleep" during labor is not morally justifiable, when judged by the general moral principles that should govern medical practice.

"Twilight Sleep" is defined by Dorland as "a condition of light anesthesia marked by mental subconsciousness, produced by the hypodermic administration of morphine and scopolamine. In this state the patient, while responding to pain, does not retain it in her memory. It is employed in the conduct of labor."

According to the general principles of morality, a physician, in his medical practice, is obliged to use only safe means when these are available, and furthermore, in administering a drug or treatment that is likely to have two effects, one good and the other evil, the good effect intended must be at least of equal im-

portance with the evil effect whose risk is assumed. Both of these principles are violated in the use of "Twilight Sleep" in ordinary medical practice, because, even under the most favorable circumstances, it cannot be truly said to be a safe means, and secondly, the risk assumed in the treatment far exceeds the good effect intended. Therefore, judged according to the moral principles that should regulate medical practice, and viewed in the light of the experience of many of the most skilful and expert obstetricians of the country, it may be truly said that the use of "Twilight Sleep" in ordinary medical practice is not morally justifiable.

In positive proof of these statements, it may be well to cite here certain extracts from Dr. O'Malley, which embody the experience of a number of the most scientific and efficient obstetricians of the country:

"Dr. Charles M. Green, professor of obstetrics in Harvard University, tells us: 'My own observations, published in 1903, led me at the time to favor this therapeutic means of producing the "Twilight Sleep," and removing the consciousness of pain, or at least preventing all remembrance of it. I have long since abandoned this agent, however, for two reasons: First, because it has apparently been the cause, occasionally, of fetal asphyxia; second, because the effect of the drug on the mother is often uncertain, and, unless used with great care, may cause unfavorable or dangerous results. Moreover, we have other and safer measures for the relief of pain in labor. So I have

given up teaching the use of scopolamine in my lectures.'

"Dr. Williams, professor of obstetrics in Johns Hopkins University, and the author of a book on obstetrics, which is very valuable, says: 'We have used the scopolamine treatment of childbirth, in two separate series of cases, at the Johns Hopkins Hospital, but in neither series were the results satisfactory, nor did they in any way approach the claims made for the treatment. We expect to do more with it next year.' In the fourth edition of his 'Obstetrics,' published in 1917, he thinks that the 'Twilight Sleep' method will fall into disuse, or, at least, that its use will be restricted to a small group of neurotic patients. From his experience, he says, the method is not adapted for private practice.

"Dr. Hirst, professor of obstetrics in the University of Pennsylvania, tried the scopolamine treatment in the maternity hospital of the university, in about 300 cases, at three different times. He tried it first in 1903, but he found, if sufficient morphine is given to abolish pain, there is danger of hemorrhage in the mother and of asphyxia in the child. At a meeting of the Obstetrical Society of Philadelphia, Hirst, commenting on a paper by Polak, said: 'I am sorry to say I cannot agree with my friend Dr. Polak in his conclusions. . . . I had to discontinue morphine and scopolamine, because there were too many cases of postpartum hemorrhage, too many cases in which forceps

had to be used, too many asphyxiated babies. So I am not an enthusiast for "Twilight Sleep." '

"Dr. Joseph B. De Lee, professor of obstetrics in the Northwestern University Medical School, Chicago, and author of a book on obstetrics which is now one of the best we have in English, tells us that the impressions he received from studying ten cases of childbirth in Professor Kronig's clinic at Freiburg, were 'decidedly unfavorable to the method of Twilight Sleep!' In all ten cases, he testifies, the birth pains were weakened, and labor prolonged—in two instances for forty-eight hours. In three cases pituitrin, which is in itself a dangerous drug to use before the uterus has been almost emptied, had to be given to save the child from imminent asphyxia. In five cases forceps had to be used, owing to the paralyzing effects of the drug, and all these forceps cases were extensively lacerated. Several of the women became so delirious and violent that ether had to be used to quiet them, with the result that the infants were born 'narcotized and asphyxiated to a degree.' One child had convulsions for several days.

"The complete failure in these ten cases is so obvious as to be a scandal, although De Lee does not say so. He abandoned the use of the method twelve years ago, and in 1913 he visited the maternities at Berlin, Vienna, Munich, and Heidelberg, and found that all had tried the method and rejected it.

"Dr. Joseph Baer reported sixty cases of the mor-

phine-scopolamine treatment at the Michael Reese Maternity Hospital in Chicago, and his results were diametrically opposed to those Dr. Polak himself obtains. The rooms were large, and had cork-lined, sound-proof, walls and doors; obstetricians and specially trained nurses were present day and night. The circumstances, then, were the best that could be had. . . .

"Baer's series ended on February 5, 1915, and of his sixty cases only five were successful.

"Holmes, one of the first in Chicago to try the newly revived method, says that in July, 1914, before the great war broke out, there were twenty-five malpractice suits pending in one German city as a result of the morphine-scopolamine fad. He quotes a noted obstetrician upon this subject: 'If you use the method, have the patient in the best hospital possible, with all the appurtenances requisite for the revival of the child; if you do not know, learn at once the differences between asphyxia, oligopnoea, and narcotic poisoning, and the methods of treating them; get the best and most reliable product called scopolamine; and then be sure you are in a position to be adequately defended by a lawyer versed in malpractice suits!"

To the above may be added the testimony of Edgar, who, in the fifth edition of "The Practice of Obstetrics," thoroughly discusses the subject of "Twilight Sleep." He writes in part as follows:

"The whole controversy now going on, and which

has agitated the medical and lay mind for the past ten years, is whether the treatment is without danger to the mother and her child. Very much the same agitation, as is now going on in the medical profession, swept over Europe and this country some ten years ago, but to a less intense degree. Most of us who practised obstetrics at that time, were carried away with this Utopian idea for a 'painless labor,' only to be brought up rather abruptly by the persistent increase of the forceps rate, lacerations in the mother, and the still-birth of a number of fetuses. I was one of the first of those who, a decade ago, was induced to give the 'twilight sleep' method a trial on one of the hospital services of the city. It required only a month's experience with the technique as then laid down to prove, that the drugs in the doses proposed would surely result in a certain number of still-births.

"The present claim for the 'twilight sleep' method, both by the Freiburg authorities and its champions in this country is, that newer and improved therapeutics and technique have today rendered the 'twilight-sleep' method entirely safe for mother and child. Nevertheless, it will be found that an inquiry into the attitude of the more prominent obstetricians in this country toward twilight sleep will point to the conclusion that most of them look upon the method as more or less of a humbug. This statement is based upon correspondence." (Edgar, pp. 837, 838.)

In concluding his discussion of the subject, Edgar makes the following statement:

"My unbiased, unprejudiced opinion is, that the method is not entirely free from danger to the two parties concerned (the mother and the child). Labor is undoubtedly prolonged. More operative interference is demanded, increasing the proportion of lacerations and traumatisms in the mother, and in spite of strong denials to the contrary, the life of the fetus will occasionally be sacrificed to the method, even under the most favorable environment." (Edgar, p. 840.)

As a result of the experience of the eminent obstetricians cited above, Dr. O'Malley most justly and logically concludes:

"This is the state of the question. Two or three men in the best circumstances say they get one hundred perfect results; other men, equally, or far more skilled, and in equally favorable circumstances, get one hundred results which are anything but successful, often a disgrace to science, and undoubtedly immoral. They are immoral, because they risk human life in an attempt to ease a physiological pain, and this is not a sufficient reason; moreover, these attempts fail oftener than they succeed." ("The Ethics of Medical Homicide," pp. 239 to 244.)

In his chapter on "Childbirth in Twilight Sleep," Dr. O'Malley treats the subject most thoroughly, from both the scientific and the practical standpoint.

What course may a Sister safely pursue with regard to the use of "Twilight Sleep" in a hospital under her direction?

Before answering this question directly, it must be remembered that in the use of this method, the moral responsibility for the risks involved rests, primarily, upon the physician; therefore, if a physician uses the method in his hospital practice without injurious results to the mother or the child, the Sister in charge is not to concern herself about its use; but if, on the contrary, serious evil should result, either to the mother or the child, from the use of the method, by the same physician, in several instances, the Sister should request the physician responsible to discontinue the employment of the method in the institution for the future.

Right to Question Surgeon in Course of Operation

Question 54: Has a Sister in charge of an operating room the right to question a surgeon, as to the purpose of the work he is doing, in the course of an abdominal operation?

Answer: Yes, she has not only the right, but it is also her duty to question him, if she has reasonable grounds to suspect that he is doing something that is not morally lawful.

The question proposed has a very practical bearing

upon the operation for cesarean section. Many obstetrical works teach that sterilization should be made a part of nearly every operation for cesarean section. As a result of this teaching, many surgeons, after performing cesarean section, proceed to resect or totally excise the Fallopian tubes as a means of preventing future pregnancies. Such a practice is immoral, and a Sister who suspects that a surgeon is about to remove healthy tubes, healthy ovaries, or a healthy uterus, has not only a right to question him, but a grave duty to do so. The more prudent course is to forestall such a contingency, by having a thorough understanding about the nature of the operation before it is begun.

Right to Tell A Surgeon not to Remove Ovaries or the Uterus

Question 55: Has a Sister the right to question the surgeon, or tell him not to remove ovaries, or to do a complete hysterectomy?

Answer: This question has been substantially answered by the answer to the preceding question. Ordinarily a Sister has no right to tell a surgeon not to remove ovaries, or to do a complete hysterectomy, because if these organs are at all diseased, the surgeon must be the sole judge of what is to be done regarding their removal. However, if these organs are evidently healthy, and a Sister has reasonable grounds

for suspecting that the surgeon is removing them for the purpose of sterilizing the patient, the Sister has not only the right but the duty to question him.

Doubt Regarding Curettage

Question 56: If curettage is slated on the board, how is the Sister to know whether it is for the purpose of abortion or not?

Answer: This question is best answered by stating that a Sister in charge of an operating-room has a right to know, in advance, the exact nature of each operation that is to be performed. Therefore it should be an established rule, not only with regard to curettage, but with regard to any other operation, that a surgeon should state in advance to the Sister in charge of the operating-room, the nature of the operation he intends to perform, at least as far as his diagnosis will enable him to do so.

Absence of Fetal Heart Tones as Indication for Baptism

Question 57: Is the imperceptibility of the fetal heart beat an indication to administer Baptism *in utero,* as this is the case sometimes in normal labor?

Answer: Taken alone, the imperceptibility of the fetal heart beat is not a sufficient indication for the necessity of administering baptism *in utero.* But if

in addition to this sign, there are other indications that the child's life is in danger, baptism should be administered. In all cases of difficult parturition, when the attending physician regards the child's life as in danger, before it is fully delivered, it should be baptized if possible, according to the instructions which follow this question under the heading "Baptism."

Questions in Connection with Baptism

In connection with Baptism, a number of questions may arise, that are closely related to matters treated in the preceding part of this manual; hence it may be well to give here a few practical suggestions upon this subject.

Canons 746 and 747 of the New Code of Canon Law bear directly upon this point. Canon 746 states:

1. Let no child be baptized while enclosed in its mother's womb, provided there is probable hope that, being rightly born, it may be baptized.

2. If the infant's head should emerge and there is imminent danger of death, it should be baptized on the head; and if it is afterwards born alive, it must not be again baptized even conditionally.

3. If some other member should emerge, it should be baptized on this member, if the danger is imminent; but then, if being born it should survive, it must be baptized again conditionally.

4. If a pregnant mother should die, the fetus, hav-

ing been extracted by those upon whom this duty devolves, should be baptized absolutely, if it is certainly alive; if doubtfully alive, it should be baptized conditionally.

5. A fetus baptized in the uterus should be again baptized conditionally after birth.

The words of the above canon are very clear and hardly need comment.

First, the canon states, that in any case where there is probable hope of a child being born alive, no attempt should be made to baptize it in its mother's womb.

Second, if for any reason there is imminent danger of the child dying before it has been fully delivered, the canon directs that, in such a case, when the head emerges, the child is to be baptized upon the head; and since such baptism is certainly valid, the canon further directs that the child should not be again baptized, even conditionally, if it survives birth.

Third, if for any reason there is imminent danger of the child dying before it has been fully delivered, the canon directs that, in such a case, if some member other than the head emerges first, the child is to be baptized upon that member, but since baptism, under such conditions, administered upon some member other than the head, is of doubtful validity, the canon further directs that if such a child survives birth, it must be again baptized conditionally.

Under the circumstances, conditional baptism is administered by using the following form: "If thou art

not baptized, I baptize thee in the Name of the Father and of the Son and of the Holy Ghost."

Fourth, the canon directs that, if a mother dies during pregnancy, the fetus should be extracted by those upon whom this duty devolves. This duty devolves primarily upon the physician in attendance, and upon the relatives of the mother. If a Catholic mother dies under such circumstances in a Catholic hospital, the Sister in charge should acquaint the physician and relatives of the mother with the obligation of having the fetus extracted. If the mother dies in the absence of the attending physician, and the Sister finds it impossible to summon him within a few minutes, she should, with the consent of the relatives, engage the services of some other physician to extract the fetus without delay. Many serious difficulties may be obviated if the Sister in charge will forewarn the relatives of the probable death of the patient, and obtain in advance their consent to the operation. If the relatives persist in a refusal to consent to the operation, the obligation of the Sister ceases.

This provision of the canon is not restricted to any particular stage of pregnancy. As quoted by Father Ferreres, Dr. Blanc states: "The Catholic physician is obliged to perform the cesarean operation in all stages of pregnancy, beginning with the period when the embryo is distinguishable and has the form of a fetus." ("Death Real and Apparent," pp. 36, 37.)

The human embryo is distinguishable and has the

form of a fetus as early as the end of the fourth week of gestation. This fourth provision of the canon is based upon the fact that the fetus often survives the mother who dies before delivery, and therefore nothing should be left undone to extract the fetus without delay, because, under the circumstances, there is nearly always a chance to administer baptism, and thereby secure eternal life for the fetus, and, in cases where the fetus has reached the term of viability, there is also a chance to preserve its temporal life.

Regarding the operation for the extraction of the fetus, Father Ferreres writes as follows: "Since cases of apparent death are not uncommon in pregnant women, and since it is important—in order to secure the fetus alive—that the cesarean operation should take place as soon as possible, two points are to be borne in mind: (1) that there be certainty of the mother's death; (2) that the cesarean operation, or any other operation deemed necessary, be performed with the same caution and care as in the case of a living mother, so that, if alive, she may not be killed, as unfortunately has taken place more than once." ("Death Real and Apparent," pp. 38–39.)

Treating this subject from a medical point of view, Edgar, in reply to the question, "Can the fetus live after the death of a mother?" states: "While we may be permitted a doubt in such a case as that of Reiss, in which, according to that author, a day passed before a living child was born, the answer to the

question must be in the affirmative, when the interval is only an hour or less." (Edgar, p. 650.)

Antonelli in his work on Pastoral Medicine refers to a number of cases in which children have been extracted alive from the womb from fifteen to twenty-four hours after the death of their mothers. Speaking of such cases, he says modern obstetricians explain them by asserting that either they are not true, or the mothers were only apparently dead, and not actually so. However, he remarks that these assertions are somewhat gratuitous and do not disprove the testimony of trustworthy physicians, who have reported the cases referred to. ("Medicina Pastoralis," Vol. I, pp. 259, 260.)

De Lee writes as follows upon cesarean section after the death of the mother:

"In recent times the operation has often been done, and the results are more encouraging. If the pregnancy has advanced beyond the twenty-sixth week, no delay is to be allowed after life is positively extinct, but the belly opened at once. It is not even necessary legally to obtain consent of the husband or the family, though for his own protection the accoucheur should get it if possible. Bacon, of Chicago, in 1911, proved this. Nor should precious minutes be lost trying to hear heart-tones, because several children have been saved when they were inaudible.

"The Talmudists, and the Catholic law, demand that the cesarean section be performed on the dying woman

to save the child, but this operation, painful to all concerned, has rarely been done. If the woman's death is only a matter of a few hours, this being the opinion of a consultation of physicians, and the child is living and viable, the operation is indicated, but here, legally, it is needful to get the consent of the husband or the next of kin. In practice it may be required to prepare for the operation, and, awaiting the woman's death, to watch the heart-tones, operating before death only if the child shows signs of distress. Naturally, if conditions are right for a quick delivery from below, this is preferable. In Strassburg, a woman with mitral disease was operated on, supposedly in agony, but it was only catalepsy, and she recovered." (De Lee, p. 1004.)

With reference to the concluding paragraph above quoted from De Lee, it must be most carefully noted that Catholic moralists positively teach that a physician is morally bound to abstain from having recourse, either to the cesarean section, or even to a forced delivery, in an effort to save the child, if he feels morally certain that the cesarean section, or the forced delivery, under the circumstances, will directly result in the death of the mother. Under such conditions, he is obliged to await the death of the mother, and then extract the fetus without delay.

Fourth, after the fetus has been extracted from a mother who has died during pregnancy, canon 746 directs that if the fetus gives evident signs of life,

it should be baptized absolutely with the ordinary form; but if the fetus is doubtfully alive, that is, if it does not give evident signs of life, yet does not show signs of putrefaction, it should be baptized conditionally, with the form: "If thou art alive, I baptize thee in the Name of the Father and of the Son and of the Holy Ghost."

In complying with this provision of the canon, it must be borne in mind that baptism conferred upon a fetus enveloped in the membranes is not a valid baptism, consequently, if the fetus is extracted, enveloped in the membranes, these must be opened before baptism is conferred.

Fifth, the canon directs that if a fetus has been baptized in the uterus, it should be again baptized conditionally after birth. This refers to cases where baptism has been conferred upon the fetus, when the *os uteri* is only partially, or not, dilated and, consequently, it is practically impossible to determine whether the water has flowed upon the head of the child.

Canon 747 says: Let care be exercised that all abortive fetuses, at whatever time they are expelled, be baptized: absolutely if they are certainly alive; conditionally if they are doubtfully alive.

Practical Directions

Very practical directions for fulfilling most of these

provisions of Canon Law, are given by Rev. John Fletcher in a work entitled "Notes for Catholic Nurses" (pp. 25 to 33). They are as follows:

"In the case of a child which apparently is 'still-born,' that is to say, a full-time, or nearly full-time child, born dead, do not quickly conclude that it is really dead. Experience proves, over and over again, how many children, born after a protracted labor, take on an appearance of death lasting for a considerable time, and are only resuscitated after hours of artificial respiration. The writer well remembers a case in which a child, born apparently dead, was put on one side for two hours, as the mother required instant and continuous attention, and was later revived. If the child shows the slightest sign of life, baptize it in the ordinary way, as described above. If the child appears dead, there is still a hope, for while it is not lawful to baptize a dead child, the only sign of true death is the presence of putrefaction, and if that be absent there is the possibility of latent life, and the child can be baptized conditionally. "Never is the judgment about the presence or extinction of life so subject to error, as in cases of the fetus within the womb, or in the act of deliverance." (Dr. Barnardes.)

Practical Conclusions

"1. In all cases of 'still birth' in which there are no signs of putrefaction, conditionally baptize the

it should be baptized absolutely with the ordinary form; but if the fetus is doubtfully alive, that is, if it does not give evident signs of life, yet does not show signs of putrefaction, it should be baptized conditionally, with the form: "If thou art alive, I baptize thee in the Name of the Father and of the Son and of the Holy Ghost."

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Canon 747 says: Let care be exercised that all abortive fetuses, at whatever time they are expelled, be baptized: absolutely if they are certainly alive; conditionally if they are doubtfully alive.

Practical Directions

Very practical directions for fulfilling most of these

by difficulties or doubts, but give the child at least the chance of eternal happiness. Though, from the nature of things, there must be some doubt regarding the validity of such a baptism, yet, as you see, there are very cogent reasons why it should be attempted.

"It is necessary that the water should come in contact with the body of the child, and therefore 'the membranes' must have broken. Baptism on the membranes is no baptism at all, as they are maternal and no part of the child. If the part presenting, which the water reaches, is other than the head, the baptism will be of doubtful validity. As the head presents in about 90 per cent. of the cases of labor, that is so much in favor of the child's chance of valid baptism.

"METHOD—Use a syringe which has been rendered aseptic and fill it with boiled water. If the membranes have not broken, they must be ruptured and the amniotic fluid discharged. The syringe is then carefully inserted in the vagina, and the water directed against the child's head, while at the same time you say the form of baptism. Do this without hurry, and be careful not to injure the parts.

"The water should be boiled and cooled to the temperature of the body before use.

"If the syringe is aseptic and the water boiled, there will be no danger of infecting the mother.

"If the *os uteri* be only partially dilated, it will be better to eject the water during 'a pain'. If the *os*

uteri be undilated, a valid baptism is practically impossible.

"As there is always a doubt with regard to the validity of intra-uterine baptism, in practice you should baptize again conditionally after it is born, pouring water on the child's head and saying: 'If thou art not baptized, I baptize thee in the Name of the Father, and of the Son, and of the Holy Ghost.'

"If the child's head is born, but not the rest of the body, and death is feared, you will baptize in the ordinary way, and conditional baptism will not be required afterwards. The umbilical cord is only a temporary part of the child, and baptism performed upon it is certainly invalid.

"Intra-uterine baptism should be performed in all cases of difficult parturition, whether the difficulty be due to the mother or to the child, where death of the child before birth is feared. Of this danger the doctor must be the judge and you must be guided by his decision. If the doctor will do so, it will be better that he should perform the baptism.

"The most frequent cases in which this necessity will arise are protracted labor, difficult presentations, constricted pelvis, *hydrocephalus,* and *eclampsia.* In cases of *placenta praevia* and grave uterine hemorrhage, it seems almost impossible to baptize *in utero* —certainly impossible for a nurse, and should not be attempted. Do not forget the terrible danger to the mother in these cases, and see that she has the Last

Sacraments. There are a few other conditions in which intra-uterine baptism may be needed, but they are cases where only a doctor might accomplish it.

"In cases of abortion or miscarriage before the fifth month of pregnancy, intra-uterine baptism is impossible, and to attempt it would be to subject the mother and the child to grave danger. No one has the right to increase the mother's peril for a very doubtful spiritual effect on the child.

"If, however, the immature product of conception be passed, the question—and the most difficult question—is to determine whether it be living or dead. As every embryo has a rational soul, it follows that every fetus, prematurely expelled from the womb, should be baptized, if living; baptized conditionally ('if thou art alive,' etc.) if life be uncertain, and left alone if certainly dead.

"Make sure that what is passed is an embryo before you baptize it conditionally. Do not try and give the Sacrament to a large, decomposed, blood clot, for instance. The *ovum* varies in size according to its age, and is generally covered with its membranes when expelled. If passed covered with the membranes, these must be quickly opened, and the foetus baptized conditionally. If small, it may be baptized by immersion. Place it in a small bowl of water, rupture the membranes with your thumb and forefinger and at the same time say, 'If thou art alive, I baptize thee,' etc., and take it immediately out of the water. The

advantage of this method is that you lose no time, and you have not to search for the head.

"With regard to abnormal fruits of conception, these misfortunes are fortunately very rare and die soon after birth. If they possess a head and breast, they should be baptized. Unless there be immediate danger of death, leave the question of baptism to the priest."

In addition to the above the author gives the following note:

"In cases of intra-uterine baptism, by a decree of the Sacred Office, August 21, 1901, a solution of one part bichloride of mercury in 1,000 parts of water is allowed, if the use of plain water would be dangerous to the mother—not, unless danger be present. The author, in any case, prefers the boiled water recommended in the text."

MEDICAL VOCABULARY

A

Abortion (ab-or'shun). The expulsion of the fetus before it is viable.

Abrup'tio placen'tae. Premature detachment of the placenta.

Accoucheur (ah-koosh-er'). One skilled in midwifery; an obstetrician.

Adnexa (ad-neks'ah). Appendages or adjunct parts; *adnexa uteri,* the ovaries and the Fallopian tubes.

Amnion (am'ne-on). The innermost fetal membrane, forming the bag of waters; the sac that encloses the fetus and forms a sheath for the umbilical cord.

Amniotic (am-ne-ot'ik). Pertaining to the amnion.

Ampullary (am-pul'ar-e). Pertaining to an ampulla, which is defined as any flask-like dilation; especially the dilated end of the Fallopian tube.

Anemia (an-e'me-ah). A condition in which the blood is deficient either in quantity or quality.

Anteflexion (an-te-flek'shun). An abnormal forward curvature; a form of displacement in which the upper part of the organ is bent forward.

Ante partum (an'te par'tum). Latin for "before delivery."

Asphyxia (as-fiks'e-ah). Suffocation; also suspended animation from suffocation or a deficiency of oxygen in the blood.

Atrophy (at'ro-fe). A wasting or diminution in the size of part; defect or failure of nutrition.

B

Bacteremia (bak-ter-e'me-ah). The presence of bacteria in the blood.

Bacteria (bak-te're-ah). Vegetable micro-organisms.

Bacterial (bak-te're-al). Pertaining to or caused by bacteria.

Basedow's disease (bas'id-oz). Exophthalmic goiter; enlarged

thyroid accompanied with abnormal protusion of the eyeballs, anemia, and overaction of the heart, and marked by mental irritability, muscular weakness, and general organic disturbance.

Bandl's ring (ban'dl). A ring-shaped thickening of the uterus during labor, just above the internal os, and marking the lower limit of the contractile portion of the uterus.

Brachiotomy (bra-ke-ot'om-e). The surgical or obstetric cutting or removal of an arm.

Broad ligament. The peritoneal fold which supports the uterus on either side.

C

Carcinoma (kar-sin-o'mah). A malignant tumor or cancer.

Catalepsy (kat'ah-lep-se). A nervous disease marked by attacks of total suspension of voluntary motion and sensibility.

Celiotomy (se-le-ot'o-me). Surgical incision into the abdominal cavity.

Cell-fission. The division of a cell into parts; segmentation.

Cephalotrypsy (sef'al-o-trip-se). The crushing of the fetal head in order to facilitate delivery.

Cervix (ser'viks). The neck or any neck-like part; *cervix uteri*, the lower and narrow end of the uterus, between the os and the body of the organ.

Cervical (ser'vik-al). Pertaining to the cervix.

Cesarean section (se-za're-an). Delivery of the fetus by an incision through abdominal and uterine walls.

Chorea (ko-re'ah). St. Vitus' dance; a convulsive nervous disease with involuntary and irregular jerking movements.

Cleidotomy (kli-dot'o-me). The operation of dividing the clavicle of the child in difficult labor, in order to permit the passage of the shoulders.

Clonic (klon'ik). Pertaining to or of the nature of a clonus, which in turn is defined as a spasm in which rigidity and relaxation succeed each other.

Coma (ko'mah). Profound stupor occurring in the course of a disease or after severe injury.

Conjugata vera (kon-ju-ga'tah ve'ra). The diameter of the pel-

vis measured from the upper and posterior part of the pubic symphysis to the second sacral ligament.

Craniotomy (kra'ne-ot'o-me). The cutting in pieces of the fetal head to facilitate delivery.

Curet (ku-ret'). A kind of scraper or spoon for removing growths or other matter from the walls of cavities.

Curettage (ku-ret-ahzh'). The use of the curet, or treatment by the curet.

Curettement (ku-ret'ment). Same as curettage.

Cyst (sist). Any sac, normal or other, especially one which contains a liquid or semisolid.

Cystic (sis'tik). Pertaining to a cyst.

D

Decapitation (de-kap-it-a'shun). The removal of the head of a fetus.

Degenerative (de-jen'er-a-tiv). Of or pertaining to degeneration, which is defined as deterioration, or change, especially of tissue to a lower or less functionally active form.

Deoxidize (de-oks'id-īz). To deprive of chemically combined oxygen.

Diabetes (di-ab-e'tez). A disease marked by habitual discharge of an excessive quantity of urine.

Diagnosis (di-ag-no'sis). The art of distinguishing one disease from another; the determination of the nature of a case of disease.

Differential diagnosis. The distinguishing between two allied diseases by constrasting their symptoms.

Dilatation (di-la-ta'shun). The condition of being dilated or stretched beyond the normal dimensions.

E

Eclampsia (ek-lamp'se-ah). A sudden attack of convulsions.

Eclamptic (ek-lamp'-tik). Pertaining to or of the nature of eclampsia.

Ectopic (ek-top'ik). Out of the normal place.

Ectopic gestation. Extra-uterine gestation or pregnancy in which the products of conception are developed outside of the walls of the uterus.

Embryo (em'bre-o). The fetus in its earlier stages of development especially before the end of the third month.

Embryotomy (em-bre-ot'o-me). The cutting up of a fetus to facilitate delivery.

Endometritis (en'do-me-tri'tis). Inflammation of the endometrium or lining membrane of the uterus.

Enucleation (e-nu-kle-a'shun). The removal of a tumor or other body in such a way that it comes out clean and whole, like a nut from its shell.

Etiology (e-te-ol'o-je). The study or theory of the causation of any disease; the sum or knowledge regarding causes.

Etiological (e'te-o-log'ik-al). Pertaining to etiology.

Excise (ex-siz'). To cut away or take out.

Exenteration (ex-en-ter-a'shun). The same as evisceration, which is defined as removal of the entrails or viscera.

Extraperitoneal (ex'trah-per-it-o-ne'al). Situated or occurring outside the peritoneal cavity.

Extra-uterine. Situated or occurring outside the uterus.

F

Fallopian tube (fal-o'pe-an). The duct passing from either uterine cornu to the ovary, and serving to convey the ovum from the ovary to the uterus and the spermatozoa to the ovary.

Feticide (fe'tis-ide). The destruction of the fetus in the uterus.

Fetus (fe'tus). The unborn offspring of any viviparous animal.

Fibroid (fi'broid). Resembling a fibroma or a fibrous structure.

Fibroma (fi-bro'mah). A tumor composed mainly of fibrous or fully developed connective tissue.

Fibromyoma (fi'bro-mi-o'mah). Fibroma blended with myoma; a tumor containing fibrous and muscular tissue.

Fimbria ovarica (fim'bre-ah o-va'rik-ah). The longest of the fimbriae (fringes) of the oviduct or fallopian tube.

Fission (fish'un). The division of a cell into parts.

Fulminant (ful'min-ant). Sudden, severe; coming on suddenly with intense severity.

Fundal implantation; implantation in the fundus of the uterus.

G

Gangrenous (gan'gre-nus). Affected with or of the nature of gangrene.

Gestation (jes-ta'shun). Pregnancy; gravidity.

Gonococcus (gon-o-kok'us). A bacterial coccus, the specific organism of gonorrhea.

Gonorrheic (gon-or-e'ik). Of or pertaining to gonorrhea, which is defined as a contagious catarrhal inflammation of the genital mucous membrane.

Gravid (grav'id). Pregnant.

Gynecological (jin-e-ko-loj'ik-al). Pertaining to gynecology, which is defined as that branch of medicine which treats of women's constitution and diseases, especially of the genital, urinary, and rectal diseases occurring in women.

H

Haemostasis or *hemostasis* (hem-os'tas-is). The arrest of an escape of blood; the checking of the flow of blood through any part or vessel.

Hematosalpinx (hem'at-o-sal'pinks). A collection of blood in an oviduct (fallopian tube).

Hemoptysis (hem-op'tis-is). The spitting of blood.

Hemorrhage (hem'or-aj). A copious escape of blood from the vessels.

Hydatidiform mole (hi-dat-id'if-orm). A false mole formed by the proliferation (reproduction or multiplication of similar forms) of the Chorionic villi.

Hydramnios, hydramnion (hi-dram'ne-os), (hi-dram'ne-on). Dropsy of the amnion, excess of amniotic fluid.

Hydrocephalus (hi-dro-sef'al-us). A fluid effusion within the cranium. The disease is marked by enlargement of the head, with prominence of the forehead, atrophy of the brain, mental weakness, and convulsions.

Hydrosalpinx (hi-dro-sal'pinks). The distention of an oviduct (fallopian tube) with a watery fluid.

Hyperemesis (hi-per-em'e-sis). Excessive vomiting. *Hyperemesis gravidarum,* the pernicious vomiting of pregnancy.

Hysterectomy (his-ter-ek'to-me). The operation of excising the uterus, performed either through the abdominal wall (abdominal hysterectomy) or through the vagina (vaginal hysterectomy).

Hysteria (his-te're-ah). A disease, mainly of young women, characterized by the lack of control over acts and emotions, by morbid self-consciousness, by exaggeration of the effect of sensory impressions, and by simulation of various disorders.

I

Incarceration (in'kar-ser-a'shun). Unnatural retention or confinement of a part.

Interstitial (in-ter-stish'al). Pertaining to or situated in the interstices or interspaces of a tissue.

Intraperitoneal (in'trah-per-it-o-ne'al). Situated within the peritoneal cavity.

Inviable (in-vi'ab-l). Not capable of living outside of the uterus.

Ischiopubiotomy (is-ke-o-pu-be-ot'o-me). Division of the ischial and pubic rami in otherwise impossible labor.

Isthmial (is'me-al). Pertaining to any isthmus (a narrow passage connecting two larger parts, as the narrow part of the fallopian tube where it joins the uterus).

L

Laparotomy (lap-ar-ot'o-me). Surgical incision through the flank; less correctly, abdominal section at any point.

Laryngitis (lar-in-ji'tis). Inflammation of the larynx, a condition attended with dryness and soreness of the throat, hoarseness, cough, and difficulty in swallowing.

Lesion (le'zhun). Any hurt, wound, or local degeneration.

Leukemia (lu-ke'me-ah). A fatal disease with a marked increase of leukocytes (white corpuscles) in the blood, together with enlargement and proliferation of the lymphoid tissue of the spleen, lymphatic glands, and bone-marrow.

Ligate (li'gāt). To tie or bind with a ligature (a thread or wire for tying a vessel or strangulating a part).

Ligation (li-ga'shun). The application of a ligature.

Liquor amnii. The liquid contained in the amnion, the amniotic fluid.

Lymphangitis (lim-fan-ji'tis). Inflammation of the lymphatic vessel or vessels.

M

Malaria (mah-la're-ah). A febrile disease, caused by a blood parasite.

Malpractice (mal-prak'tis). Improper or injurious practice; unskilful and faulty medical or surgical treatment.

Meconium (me-ko'ne-um). The fecal matter discharged by the new-born.

Median (me'de-an). Situated in the middle.

Membrane (mem'bran). A thin layer of tissue which covers a surface or divides a space or organ. Fetal membranes consist of the chorion, amnion, and allantois.

Menopause (men'o-pawz). The period when menstruation normally ceases; the change of life.

Menstruation (men-stru-a'shun). The monthly sanguineous discharge peculiar to women.

Metastasis (mĕt-as'tas-is). The transfer of disease from one organ or part to another not directly connected with it.

Mitral (mi'tral). Shaped somewhat like a miter; pertaining to the mitral valve.

Mononuclear (mon-o-nu'kle-ar). Having but one nucleus; a cell having a single nucleus.

Morphia. Latin for morphine.

Mutilation (mu-til-a'shun). The act of depriving of a limb, member, or important part; or the inhibition (restraining) of the function of a distinct organ of the human body.

Myocarditis (mi'o-kar-di'tis). Inflammation of the muscular walls of the heart.

Myoma (mi-o'mah). Any tumor made up of muscular elements.

Myomata. Plural of myoma.

Myomatous (mi-o'mat-us). Pertaining to or of the nature of a myoma.

N

Narcosis (nar-ko'sis). A state of profound unconsciousness produced by a drug.

Narcotic (nar-kot'ik). Producing sleep or stupor; any drug that produces sleep or stupor and at the same time relieves pain.

Narcotise (nar'kot-iz). To put under the influence of a narcotic.
Necrosis (ne-kro'sis). Death of a circumscribed portion of tissue.
Necrotic (ne-krot'ik). Pertaining to or affected with necrosis.
Neurasthenia (nu-ras-the'ne-ah). Nervous prostration; depression due to the exhaustion of nerve energy.
Neurosis (nu-ro'sis). A nervous disease; more especially a functional disorder of the nervous system; a disorder of the nervous system not dependent upon any discoverable lesion.
Neurotic (nu-rot'ik). Pertaining to or affected with a neurosis; pertaining to the nerves.
Nodule (nod'ūl). A small boss or node (swelling or protuberance).

O

Obstetrics (ob-stet'riks). The art of managing childbirth cases; that branch of surgery which deals with the management of pregnancy and labor.
Oligopnoea (ol'ig-op-ne'ah). Retarded breathing.
Omentum (o-men'tum). A reduplication of the peritoneum going from the stomach to the adjacent organs.
Oophorectomy (O'of-o-rek'to-me). The surgical removal of an ovary.
Operability (op-er-a-bil'it-e). Capable of being operated upon with reasonable hope of improvement.
Os (os). *Os uteri externum,* the lower extremity of the canal of the *cervix uteri; os uteri internum,* the internal or upper orifice of the canal of the *cervix uteri.*
Ovarian (o-va're-an). Pertaining to an ovary or the ovaries.
Ovariotomy (o'va-re-ot'o-me). Surgical removal of an ovary; or, more commonly, the removal of an ovarian tumor.
Ovary (o'va-re). The female sexual gland in which the ova are formed. It is a flat, oval body connected with the posterior surface of the broad ligament.
Ovulation (o-vu-la'shun). The formation and discharge of an unimpregnated ovum from the ovary.
Ovum (o'vum). An egg; the female reproductive cell which, after fertilization, develops into a new member of the same species.

Oxytocic (oks-e-to'sik). Hastening the process of childbirth; a medicine which accelerates delivery.

P

Paroxysm (par'oks-izm). A sudden reoccurrence or intensification of symptoms.

Parturient (par-tu're-ent). Giving birth; pertaining to childbirth.

Pelvic (pel'vik). Pertaining to the pelvis.

Pelvis (pel'vis). Any basin-like structure; the basin-shaped ring of bone at the posterior extremity of the trunk, supporting the spinal column and resting upon the lower extremities.

Perforation (per-fo-ra'shun). The act of boring or piercing through a part or substance.

Peritoneal (per-it-o-ne'al). Pertaining to the peritoneum.

Peritoneum (per'it-o-ne'um). The serous membrane which lines the abdominal walls and invests the contained viscera. It is a strong colorless membrane, with a smooth surface, and forms a closed sac except in the female, in whom it is continuous with the mucous membrane of the fallopian tubes.

Pernicious anemia. A severe disease, without discoverable cause, marked by a progressive diminution of the red corpuscles of the blood, with the usual symptoms of anemia, and often with emaciation, fever, and hemorrhage into the retina.

Pernicious vomiting. Vomiting in pregnancy, so severe as to threaten the life of the patient.

Pessary (pes'ar-e). An instrument placed in the vagina to support the uterus or rectum; a medicated vaginal suppository.

Phimosis (fi-mo'sis). Tightness of the foreskin, so that it cannot be drawn back from over the glans; also the analogous condition in the clitoris.

Phlebitis (fle-bi'tis). Inflammation of a vein.

Phlebotomy (fle-bot'o-me). The opening of a vein for bloodletting; venesection.

Pituitrin (pit-u'it-rin). A proprietary preparation of the posterior lobe of the pituitary body; used to promote uterine contractions in *inertia uteri.*

Placenta (pla-sen'tah). The round, flat organ within the uterus

which establishes communication between the mother and child by means of the umbilical cord.

Placenta praevia (prae'via). A placenta which intervenes between the intra-uterine cavity and the inner orifice of the cervical canal.

Placental (pla-sen'tal). Pertaining to the placenta.

Polyhydramnion (pol'e-hi-dram'ne-on). Excess in the amount of the liquor amnii (amniotic fluid) in pregnancy.

Polymorphonuclear (pol'e-mor-fo-nu'kle-ar). Having nuclei of many forms.

Porro's (por'oz) operation. Cesarean section followed by removal of the uterus, ovaries, and fallopian tubes.

Pregnancy (preg'nan-se). The condition of being with child; gestation.

Premature delivery. Delivery of a viable child before the end of the normal term of gestation.

Primipara (pri-mip'ah-rah). A woman who has given birth or is giving birth to her first child.

Primordial (pri-mor'de-al). Original or primitive; of the simplest and most undeveloped character.

Prognosis (prog-no'sis). A forecast as to the probable result of an attack of disease; the prospect as to recovery from a disease afforded by the nature and symptoms of the case.

Prolapse (pro'laps). The falling down or sinking of a part or viscus.

Pronucleus (pro-nu'kle-us). The nucleus of the egg-element or of the sperm-element after the coalition of the spermatozoon with the ovum.

Psychasthenia (si-kas-the'ne-ah). A functional neurosis marked by states of pathologic fear or anxiety, obsessions, fixed ideas, tics (sudden spasms), feelings of inadequacy, and peculiar feelings of strangeness, unreality and dispersonalization.

Puberty (pu'ber-te). The age at which the reproductive organs become functionally operative.

Pubiotomy (pu-be-ot'o-me). The operation of cutting through the pubic bone lateral to the median line.

Puerpera (pu-er'per-ah). A woman in childbed.

Puerperal (pu-er'per-al). Pertaining to childbirth.

Q

Quickening (kwik'en-ing). The first recognizable movements of the fetus in the uterus.

R

Reflex (re'flecks). A reflected action or movement.

Renal (re'nal). Pertaining to the kidney.

Resection (re-sek'shun). Excision of a part of an organ.

Residue (rez'id-u). A remainder; that which remains after the removal of other substances.

Retinitis (ret-in-i'tis). Inflammation of the retina.

Retroflexion (re-tro-flex'shun). The bending of an organ so that its top is thrust back.

Retroflexed. In a state of retroflexion.

S

Saline-solution. A solution of sodium chlorid, or common salt, in distilled water.

Salpingectomy (sal-pin-jek'to-me). Surgical removal of an oviduct (fallopian tube).

Salpingostomy (sal-ping-os'to-me). The formation of an opening or fistula into an oviduct (fallopian tube) for the purpose of drainage.

Segment (seg'ment). A piece cut off or marked off, either actually or by an imaginary line.

Segmentation (seg-men-ta'shun). Division into parts more or less similar, especially that which takes place in the fertilized ovum.

Segmentation-nucleus. The nucleus of a fertilized ovum formed by the union of a male with a female pronucleus and undergoing segmentation.

Sepsis (sep'sis). Poisoning by the products of a putrefactive process.

Sinus (si'nus). A recess, cavity, or hollow space; a dilated channel for venous blood.

Spermatozoon (sper'mat-o-zo'on). The motile generative element of the semen which serves to impregnate the ovum.

Spondylotomy (spon'dil-ot'o-me). The cutting of the vertebral column in surgery or in obstetrics.

Sterilization (ster'il-iz-a'shun). The act or process of rendering sterile.

Suppurate (sup'u-rate). To cause to generate pus.

Symphyseotomy (sim-fiz-e-ot'o-me). The division of the fibrocartilage of the symphysis pubis (the junction of the pubic bones), in order to facilitate delivery.

T

Tampon (tam'pon). A plug made of cotton, sponge, or oakum; variously used in surgery for the control of hemorrhage or the absorption of secretions.

Tetanically (te-tan'ik-al-e). After the manner of contractions or spasms such as occur in tetanus.

Therapeutic (ther-ap-u'tik). Pertaining to the art of healing; curative.

Therapy (ther'ap-e). The treatment of disease.

Thrombosis (throm-bo'sis). The formation or development of a thrombus, which is defined as a plug or clot in a vessel remaining at the point of its formation.

Tonic (ton'ik). Characterized by continuous tension.

Toxemia (toks-e'me-ah). Blood-poisoning. Poisoning by toxins produced in the body-cells or by the influence of microorganisms.

Toxemic (toks-e'mik). Pertaining to or caused by toxemia.

Transperitoneal (trans'per-it-o-ne'al. Crossing the peritoneum; across the peritoneum.

Traumatism (traw'mat-izm). A condition of the system due to an injury or a wound; a wound.

Tubal (tu'bal). Pertaining to a tube, as the fallopian tube.

Tumor (tu'mor). A mass of new tissue which persists and grows independently of its surrounding structures, and which has no physiologic use.

U

Umbilical (um-bil'ik-al). Pertaining to the umbilicus (the navel; the cicatrix which marks the site of the entry of the umbilical cord).

Uterine (u'ter-in). Pertaining to the uterus.

Utero-gestation. Pregnancy in which the products of conception are developed in the uterus.

Uterus (u'ter-us). The womb; a hollow muscular organ, the abode and place of nourishment of the embryo and fetus. It is a pear-shaped structure, about three inches in length, consisting of a broad flattened part (body) above and a narrow cylindric part (cervix) below. Its cavity opens into the vagina below, and into the fallopian tubes on either side above. It is held in place by a broad ligament, a transverse fold of the peritoneum which encloses it on either side, and by various other ligaments.

V

Vagina (vaj-i'nah). The musculo-membranous canal extending from the vulvar opening to the cervix uteri.

Vasectomy (vas-ek'to-me). Surgical removal of the vas deferens, or of a portion of it. The vas deferens is the excretory duct of the testicle, passing from the testis to the ejaculatory duct.

Vasotomy (va-sot'o-me). Incision of the vas deferens.

Venesection (ven-e-sek'shun). The opening of a vein for the purpose of letting blood.

Vertex (ver'teks). The summit or top.

Viability (vi-ab-il'it-e). Ability to live after birth.

Viable (vi'ab-l). Capable of living outside of the uterus; said of a fetus that has reached such a stage of development that it can live outside of the uterus.

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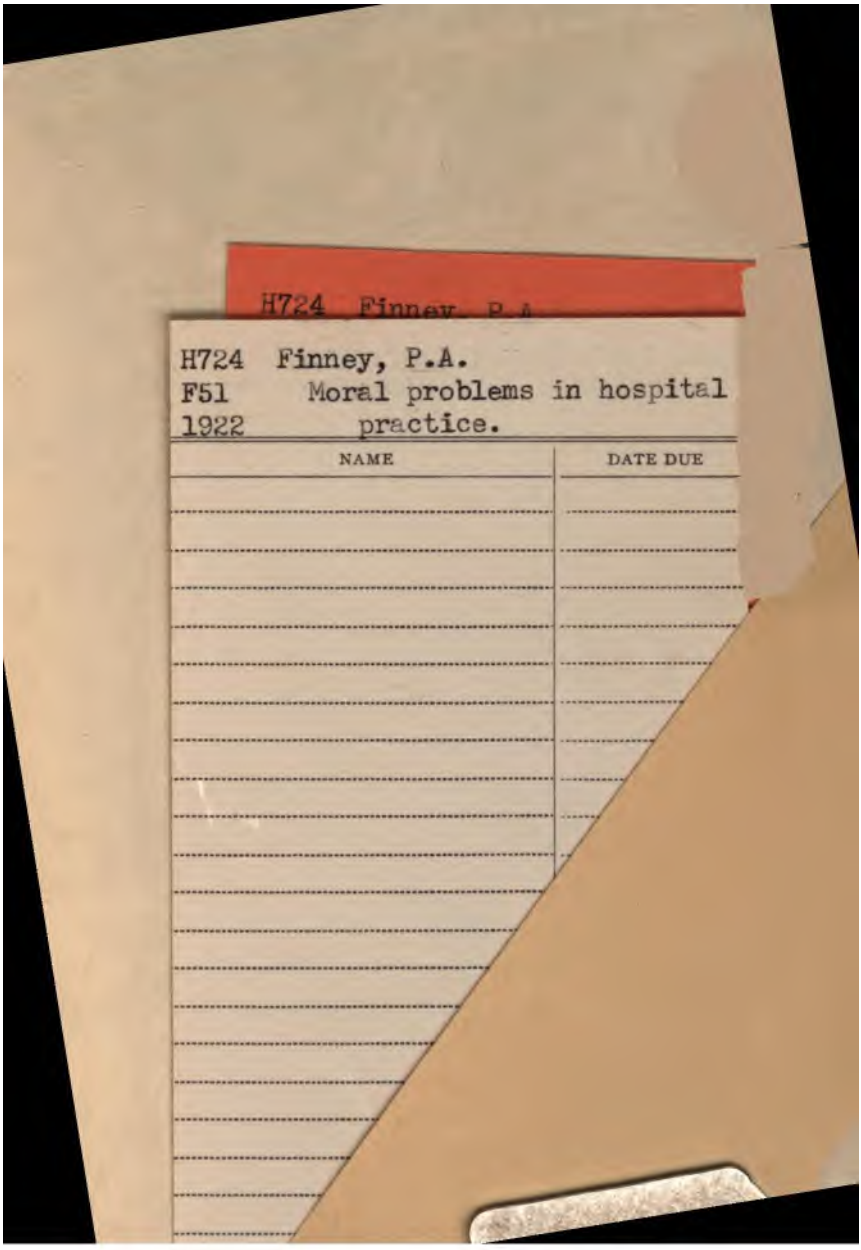
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